# EXHIBIT DX2

TO DECLARATION OF PETER J. GOSS IN SUPPORT OF DEFENDANTS' OPPOSITION TO PLAINTIFFS' MOTION TO EXCLUDE THE OPINIONS AND TESTIMONY OF DR. MICHAEL A. MONT

UNITED STATES DISTRICT COURT

DISTRICT OF MINNESOTA

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In Re:

Bair Hugger Forced Air Warming

Products Liability Litigation

This Document Relates To:

All Actions MDL No. 15-2666 (JNE/FLM)

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DEPOSITION OF MICHAEL A. MONT

VOLUME I, PAGES 1 - 369

JULY 28, 2017

(The following is the deposition of MICHAEL A. MONT, taken pursuant to Notice of Taking Deposition, via videotape, at the offices of Weisman, Kennedy & Beris, 101 West Prospect, Cleveland, Ohio, commencing at approximately 9:14 o'clock a.m., July 28, 2017.)

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I N D E X





P R O C E E D I N G S

(Witness sworn.)

MR. B. GORDON: Do you want to make appearances for the record?

Ben Gordon, Ben Gordon for the plaintiffs.

You guys want to put your appearance on the record?

MR. ASSAAD: Gabe Assaad for the plaintiffs.

MR. COFFIN: Chris Coffin for the plaintiffs.

MR. C. GORDON: Corey Gordon for the defendant.

MR. GOSS: Peter Goss for the defendant.

MS. HINES: Micah Hines or the defendant.

MICHAEL A. MONT

called as a witness, being first duly sworn, was examined and testified as follows:

ADVERSE EXAMINATION

BY MR. B. GORDON:

Q. Good morning, Dr. Mont. My name is Ben Gordon and we met a few minutes ago; did we not?

A. Yes, we did.

Q. You've had your deposition taken before I understand; right?

A. I have.



Q. How many times?

A. Hmm. Now I have to be --

Q. Approximately.

A. -- precise. Been in practice for about 30 years, and some years zero, some years three or four, so I would just say an average of two a year, so 60.

Q. Depositions, right?

A. Depositions.

Q. And you --

A. Two per year. Something like that would be a --

Q. And you gave us a testimony --

A. If you want a more -- sorry. If you want a better answer, I'd have to think about it.

Q. No, just looking for an approximate. Thank you.

So you know the ground rules. One is that we try not to talk over each other, and I'll try to let you finish if you'll let me finish my questions before you answer. And answer audibly.

A. Yes.

Q. Thank you.

You understand you're under oath; right?

A. Yes.

Q. You're to answer everything to the best of

your ability, but to give us the truth and the entire truth. You understand that; right?
A. Yes.
Q. You've been retained by 3M to work in this case as an expert witness; correct?
A. I've been retained by a -- a legal firm to represent 3M. I don't know if I would phrase it that I was directly retained by 3M.
Q. Who is it --
A. Indirect.
Q. -- that you understand retained you specifically?
A. Two different legal firms, members from two different legal firms that are representing 3M.
Maybe I'm not answering the question right.
Q. And is it your understanding that your testimony is on behalf of those legal firms or on behalf of 3M?
A. My testimony is for the truth about a specific --
In the first -- in the first position it was on two specific cases, that was the first firm, and the next was on a topical issue relevant to a whole series of cases.
Q. Let's back up.



A. But I -- I've been to -- I -- I don't --
I want to try to answer you directly and not belabor the point. I do rep --
I do agree that this is all being direct -- directly from legal firms that are representing 3M. Does that help you?
Q. And -- and --
It does. I think so. And so just to be clear, through that analysis you would concede that your testimony in this lawsuit is on behalf of 3M corporation; would you not?
MR. C. GORDON: I object to the form of the question.
MR. B. GORDON: You can answer, doctor.
A. In a general sense, yes.
Q. Okay.
A. We'll just leave it at that.
Q. You said you worked for two different law firms or were retained by two different law firms. Who is the first lawyer who contacted you in this case?
A. I'm almost 100 percent sure her name was Marcela Duca, and it's -- it's spelled D-u-c-a.
Q. Marcela Duca. Do you know what law firm she works for?



A. I could find out. But offhand, I didn't --
MR. C. GORDON: Do you want to know?
A. -- prepare --
Q. Was that in the Walton case? Was that before the MDL, if you know?
A. Yes, it was before the MDL.
Q. Walton and Johnson.
A. Yes.
Q. Okay.
A. Those two. Tommy Walton.
Q. And what time period was that, approximately, that you were first retained?
A. I don't --
If I said two years ago, I'm hazarding a big guess. I -- I'd like to give you a better answer than that.
Q. Okay. That's fine.
A. I could get it for you later. So --
By the way, any answers that I can't be that precise, I'm happy to try to get -- get for you later after this deposition.
Q. Thank you, doctor. Appreciate that.
Have you ever done any legal work or consulting work for 3M corporation before these cases?
A. To the best of my knowledge, no.



Q. You mentioned a second lawyer or law firm that contacted you after the initial contact; right?
A. Yes.
Q. And who was that?
A. That's the -- the lawyers represented here.
Q. So Corey Gordon?
A. Yes. Corey Gordon contacted me, actually at the -- yeah, at a similar time period.
Q. At a similar time period as the first retention?
A. The first retention, Corey Gordon's name was mentioned, but I didn't deal with him until a -- a few months after the first law firm.
MR. B. GORDON: Okay. Let me do this. We've got a subpoena, and I'm going to have the court reporter mark this as Exhibit 1 to your deposition and have you take a look at it, please.
(Exhibit 1 was marked for identification.)
BY MR. B. GORDON:
Q. Doctor, if you just leaf through this, this is a subpoena to testify in this case along with an attachment referred to as documents to be produced. Have you seen this before?
A. Yeah, this has a list of 18 things. Yes, I

have.
Q. And you've reviewed this with counsel I presume?
A. Yes.
Q. And in responses you've produced a number of things that counsel gave to us, some before today and some this morning; is that right?
A. I don't --
I wouldn't have knowledge of when they gave you these things. I -- I would have --
My assumption would have been that this was given to you before today, but maybe some of these things were given you -- to you today. But I don't know when those transactions occurred.
Q. We'll go through the -- the list in a moment, doctor, but you would agree with me that at least some of these things you produced to us just this morning as you walked in; is that fair?
A. I -- I will tell you that I went over these things with counsel, if we're calling that Corey Gordon and crew, and I don't know when that -- but -- hmm.
Q. Well let me -- let me -- let me ask a different question, doctor.
A. I'm not the one that handed it to you



directly. They would have handed this to you.
Q. So one of the things you've come in here with --
A. I --
Q. -- this morning, doctor, is a page of notes that I'm going to grab from you, one page of notes that we're going to mark as Exhibit 2 to your deposition real quick. Okay?
(Exhibit 2 was marked for identification.)
A. Yes. So that's a page of notes that I came in today with. Okay. So agreed that that's on this list, because I haven't looked at --
Q. We'll go over the list in a minute.
Let me just ask you a question. This Exhibit 2 is labeled "Additional" and there is a list of 13 items listed; is that right?
A. Yes.
Q. When did you prepare that list?
A. This morning.
So insofar as one of these 18 items is asking for additional materials, then -- then I'll stand corrected for one of my previous answers, that some of this I prepared, gave to you today. So that --



Q. Fair enough, doctor.
A. -- was an error.
Q. All right. Let's move on. We'll come back to that when we need to.
Let me ask you first of all before we get into these documents: What was your assignment in this case as you understand it?
A. To review the facts about a Bair Hugger device, forced-air warming device, and whether it had -- various questions about it, which I don't want to initially say one question or two questions, but whether it was defective or whether it -- it led to an increased incidence of SSIs, surgical-site infections.
Q. And you would agree with me that your role in this case is to be that of an objective, neutral witness; would you not?
A. Yes.
Q. You're not an advocate in this case for 3M; are you?
A. No.
(Witness's cellphone dings.)
Q. And in terms of the --
MR. B. GORDON: Well let's just --
Let's go ahead and mark as Exhibit 3 your --
MR. C. GORDON: Ben, hang on just one



second.
THE WITNESS: Just answering this.
MR. B. GORDON: You need to look? Okay.
THE WITNESS: I'm -- I'm --
MR. ASSAAD: Go off the record.
THE REPORTER: Off the record, please.
(Discussion off the record.)
MR. B. GORDON: Okay, doctor. Thank you. And if -- as I said earlier, if you need to take a break at any time for things having to do especially with your medical practice, just -- just say the word. Okay?
THE WITNESS: Okay.
MR. B. GORDON: Let's mark as Exhibit --
What are we on, three?
THE REPORTER: Yes.
MR. B. GORDON: -- a list of Mont reference -- Mont reference -- "Michael Mont Reference List," and I'll ask you a question about it.
(Exhibit 3 was marked for identification.)
BY MR. B. GORDON:
Q. So Dr. Mont, we've marked as Exhibit 3 something entitled "Michael Mont Reference List." Is

this a list of notes that you prepared?
A. Yes.
Q. When did you prepare this, to the best of your recollection?
A. I think it was -- I think it was June. I could give you an exact date, but I think it was like -- it might have been the weekend of -- I can look at my calendar in the phone, but I would say it was the weekend of maybe the 9th or the 16th. I'd have to go back, because I have good diaries of what I do.
Q. So just --
A. And which -- which we --
It was a weekend I re -- after June -- certainly after June 2nd and 3rd.
Q. And to be clear, you're talking about June 2nd or 3rd of this year, 2017.
A. Yes.
Q. Would this all have been compiled, to your recollection, in one sitting?
A. This was compiled over --
I believe it started on a Thursday night, Friday, Saturday, Sunday, so if we call that one --
It was like one sitting. It was a continuous -- it was a -- a free weekend that I had



to -- to work.
Q. And then, if I'm understanding correctly, doctor, based on what you've testified to already, this would have -- this list, Exhibit 3, would have been compiled after you completed your report in this case; correct?
A. Yes.
MR. B. GORDON: Okay. Let's mark as Exhibit 4 a copy of your recently updated CV that states "(revised July, 2017)," and then we'll get you to take a look at that.
(Exhibit 4 was marked for identification.)
A. So in -- in my hand is this Exhibit 4, which is the best representation of the CV that I have com -- redone yesterday just to include a few more published reports, which is about all I do at the present time to update CVs. I don't put a lot of other material in because I don't generally need -- need other material like meetings or different grants.
Q. So Exhibit 4, doctor, would be a complete, up-to-date copy of your curriculum vitae; correct?
A. Yes.
Q. Okay. Thank you, doctor. You can hang onto that. We've got one here.



MR. B. GORDON: Exhibit 5. I'd like to have the court reporter mark as Exhibit 5 a copy of your expert report in this case.
Let me have you look at it first. Does that look like your expert report?
MR. C. GORDON: Without any attachments; right?
MR. B. GORDON: Correct.
THE WITNESS: Yeah, this looks like my expert report without supplement -- what you -- what was just mentioned, without the supplemental material.
MR. B. GORDON: Okay. And we're going to mark that as Exhibit 5. Thank you.
(Exhibit 5 was marked for identification.)
BY MR. B. GORDON:
Q. And doctor, we'll give you an opportunity to talk about anything else you want to talk about, too, but for purposes of this question I want you to refer to Exhibit 5 as you need to and tell me if Exhibit 5 is a complete list of all the opinions that you have in this case.
A. It -- it's a complete list of obviously what is printed here, but I can't answer in the affirmative that it's a complete list of all my opinions. It --



it certainly is not all my opinions, but I felt at the time these were all my relevant opinions to this case. I'd like to think that's a hundred-percent-accurate statement and I -- but I can tell you that if I come up with any other opinions that I think are relevant to the case, I would let you know after this point in time.
Q. And when was this -- sorry.
A. And then in addition, again, for example, I just reviewed a new article that came out after this was written and that would give you -- might give me more opinions. And then I reviewed a few other expert reports. So to say that this is all the opinions I have in the case, it's -- it's a -- it's a case in flux, it has new materials that come out, new information, and that might add different opinions or --
But in a general sense, just to try to put this to a close, this is generally how I feel about this case in terms of the conclusions. And at this time when this was put together I thought that this was the best -- best representation of my opinions about this case.
Q. And this -- you mentioned --
By the way, you mentioned a new study that

just came out. Are you referring to the new Dr. Augustine paper?
A. Yes.
Q. And so that paper may change your opinions you say?
A. I don't know if it's a new study, by the way. I think it's a newly published study of -- but -- old work, but a new --
Q. So you believe that that study may affect your opinions.
A. I wouldn't --
I'm not even sure I would call it a study. But it -- it just supplements my opinions. I mean again, it -- I don't want to get involved in semantics.
Q. Well your opinions were already formed at the time you issued this report; correct, doctor? Before that study -- before you ever saw that study; right?
A. Yes. Yeah. It may accentuate some of my opinions. I don't know if that's a -- when you have opinions you -- you --
This report is supposed to be these are my opinions and these are why I feel this way, and then further information may add to those or make opinions



more definitive.
Q. When did you prepare that report, doctor?
A. Well I was -- you --
You could say that I was preparing this report for many months because a lot of the materials I was reviewing, including most if not all of the articles contained in these two folders, I was reviewing as the months were going by and I was formulating bits and pieces of my opinions in this report which actually made it to the final draft of this report. So in the -- in the absolute answer, this report, it was done over a few-week period before the due date, which was, I believe, June 1st or 2nd. I don't want to get wrong on that due date.
Q. You mentioned draft. You have additional drafts of that report?
A. I had drafts, but I discarded those after this report was done.
Q. There's no record of those earlier drafts?
A. No.
Q. You mentioned at the end of that report that you might supplement that report. Have you issued any supplements to that report?
A. I have not.
Q. So as we sit here today, that's your final



report.
A. As we sit here today --
Q. Okay.
A. -- this is my final report.
Q. Let's set that aside for the moment, and I want to go back to your curriculum vitae, which I think was number four.
MR. B. GORDON: Is that right, Dick?
A. Yeah.
Q. Let's look at your curriculum vitae, and I guess I'll look at this one, although I got --
Give me one second.
You have your CV in front of you, doctor?
A. Yes, I do.
Q. So I'm going to ask you a couple of specific questions about it, so bear with me.
You indicate in one place that -- I think page -- it's three on the copy I'm looking at, it may have changed --
Let's see. Bear with me. Yeah. Page three you mention "CLINICAL DUTIES," that you see approximately 4,000 outpatient visits per year; correct?
A. Yes. So I would -- I would look at this and --



Q. I'm just asking you right now: Do you see about 4,000 outpatient visits per year?
A. No. But I want to qualify my answer a little. So as I said before, basically the only thing I'm changing about this CV, because people want to know articles, that's -- the major purpose is adding articles, but a lot of the other materials I haven't changed since I came to Cleveland Clinic, which was a year ago. So presently I am --
I see what you've just pointed out. There's a whole section about how many patients I see, how many surgeries I do, and that should be changed. In fact, the next -- probably by Monday I will change that section in fact, maybe go over this. My --
All the numbers you see there have been reduced by about -- let's just say 50 percent. So my duties here is that --
These are numbers from last year when I was in Baltimore. I came to Cleveland Clinic and I'm now 50 percent to 60 percent clinical, and the 40 percent I use to be the head of the Orthopaedic Department at Cleveland Clinic.
Q. So doctor --
MR. B. GORDON: I'm going to move to strike as non-responsive.

Q. My question was simply is it correct that you see approximately 4,000 outpatients per year, and that was about a three-minute answer for a question that just required you to tell me "yes" or "no," is that an accurate --
A. I -- I --
Q. And let me finish, doctor. If it's not accurate, then tell me it's not accurate. We're going to be here a lot longer if you don't try to listen to my question and give me a responsive answer. And so I'm just asking you --
I would appreciate it if you would try, doctor. That's all I'm asking. Will you try?
MR. C. GORDON: Objection, asked and answered, and move --
Q. Will you try, doctor?
MR. C. GORDON: -- and move to strike counsel's commentary.
A. The -- the -- the answer is any question that I find, even if it's a yes/no answer, but I find can be taken out of context and to me in my opinion deserves an explanation, which I feel what I said was an appropriate explanation. In fact, I will amend this CV as of Monday to make sure it's better accurate. I'm not happy to see that this represents



my clinical productivity from last year, not my clinical productivity, because just as I am trying to answer all of your questions as accurately as possible, I like everything in print, everything that represents me, to be as accurate as possible. And I'm not a lawyer and I don't know all the rules, but when a question is asked of me and I see that there's a clear discrepancy, I'd like that clarified. I -- I don't -- I don't like my answers to be potentially taken out of context.
MR. B. GORDON: Objection, move to strike, non-responsive.
Q. My question, doctor, was will you try --
A. I will try the best --
Q. -- and you gave me another oration.
A. I -- I will try the best I can.
Q. I appreciate that. I think the jury would, too.
Doctor, --
MR. C. GORDON: Move to strike counsel's comments.
Q. -- you told us at the beginning of this deposition that you revised this curriculum vitae yesterday, I think; did you not?
A. Yes.



Q. Okay. So now you're telling us that, as soon as we get to page three, it's not complete and up to date, but you testified earlier it was up to date, --
MR. C. GORDON: Object --
Q. -- so now you're -- you're changing that answer; correct?
MR. C. GORDON: Objection, objection, asked and answered, miscon -- mischaracterizes the testimony, --
Q. Your earlier testimony --
MR. C. GORDON: -- argumentative.
Q. -- that the CV is up to date is in error; correct, doctor?
A. I'm going to answer --
MR. C. GORDON: Same objection.
A. I'm going to answer that your previous question -- which we can read your previous comment and question -- disregards the fact that I said earlier that the only thing I did yesterday to the CV was to add to get the references up to date. I didn't look at any of the other content because I'm here at Cleveland Clinic as the chairman, I don't need a CV, I'm not shipping this around, and it's not that important to me to put page three, page five, page



seven. The only thing I've been doing -- and I said this not in as much detail -- is adding references because people like to see what I've published. So what you said in the previous comment, which was attached to a question to say that I revised this whole thing, I had earlier said that the only thing I did was add things. I didn't look at the other details to revise that, which is the implication.
MR. B. GORDON: Objection, move to strike, non-responsive.
Q. Doctor, when did you come to the Cleveland Clinic precisely?
A. I've been here a number of times as I -- that question --
I had to interview -- I had to interview here to get this job, so I was here a number of times. Do you want all the dates that I interviewed?
Q. Doctor, I think my question was clear, but perhaps not.
When did you move from Baltimore, at Mount Sinai or wherever you were there, to join the staff at the Cleveland Clinic?
A. I --
That's a two-part question. I moved at a different time when I joined the staff.

Q. When did you become an employee of the Cleveland Clinic?
A. I need a break.
Q. You need a break. We've been going --
A. I need a break.
Q. -- fifteen minutes.
A. I have to discuss with counsel.
Q. Okay, doc, Let's take a break.
MR. B. GORDON: For the record, doctor needs a break after 15 minutes, nothing to do with a medical emergency, it's simply that he wants to talk with counsel.
THE REPORTER: Off the record, please.
(Recess taken.)
(Pending question read by the court reporter.)
THE WITNESS: Read the question right before that, please.
MR. B. GORDON: No. That's the pending question, doctor.
A. Okay. My first day at work was July 5th.
Q. Of this year, 2017?
A. Of 2016.
Q. Okay.
A. Sorry.



Q. And when --
Thank you.
A. July 5th, 2016 was my first day.
Q. And when did you become the chairman of the Orthopaedic Department?
A. That day.
Q. That day. Okay.
A. Maybe officially, to correct that answer, there was a holiday weekend July 4th and no -- and the July 1st date was a Friday, so theoretically I became the chairman July 1st, 2016. That would be the better answer.
Q. And as of that time, July of 2016, were you still seeing approximately 4,000 outpatient visits per year?
A. Right the -- the week before, the week before --
Actually, that would also be an inaccuracy. The number was probably -- the number from Baltimore was probably closer to 6,000, not 4,000, and the number right now at Cleveland Clinic, when I amend this on Monday, is closer to about 3200, since I just saw the numbers.
Q. So still focused on Exhibit 4, your CV, I want to ask you a couple other things to see if



they're accurate or not. You mention a number of grants on your CV, and I think these start on approximately page seven --
Make sure I'm looking at your current copy.
You see where I am, "GRANTS AND OTHER SUPPORT?"
A. Yes, I do.
Q. And a number of these total presently about 56 or so; is that accurate? Fifty-four on this list.
A. Fifty-four on this list.
Q. So in the updated one from today -- from yesterday, that's gone down from the prior one by --
No, I -- strike that. I withdraw that question.
So these 54 grants, are these ongoing grants?
A. No. I can go through each one, but many of them are -- these are --
This has not been updated in a long period of time. I'm looking here, for example, 49, that you could see it says "2008 to present;" that grant was finished. That same company has a study starting next January. Many of these are done. This has not been updated for many years.
Q. So how many of these would you say are



active grants, doctor?
A. Do you want me to go through all them? Right now I'm not --
Q. I'm looking for an approximate --
Well let me ask you --
A. Approximately zero. These were --
Q. So doctor --
A. These have not been -- I --
I have over 20 active grants right now, I have not been updating them, and every year I get 10 or 15 new ones. We finish the studies and we do new grants. This has probably not -- that grant section has not been up -- updated for -- I'd have to give you the exact date, but it may not -- it may have been eight or nine years.
Q. So currently you have approximately 20 active grants that are not reflected on this CV; is that fair?
A. Something like that, yes.
Q. And is there any particular reason, when you updated your CV yesterday, that you didn't update this section?
MR. C. GORDON: Objection, asked and answered.
A. I don't use --

I don't keep track of my grants.
Q. Well you put on the Cleveland --
A. I don't keep track of my --
I keep track of my grants, but not through my CV. I have other methods that keep track of -- of my active grants.
Q. How many --
A. And in -- sorry. And in fact, all the grants that I'm involved with are reviewed -- not all. Ninety percent of the active grants that I have at Cleveland Clinic are reviewed on a weekly basis in a morning conference, and it really -- it's not only 20 that I have, it's about 30 others that I'm peripherally involved as the chairman of the department, and then there's another 10 grants that I don't review every week but I certainly review every -- every quarter that are grants that I'm involved with -- no, it's probably 20 grants, 30 grants -- 30 other grants that I'm involved with other centers around the whole country that are re -- not reviewed on a weekly basis, but I am part of at -- at different medical centers, which I'm happy to name off if you'd like.
Q. I'd just like to know approximately, since this isn't accurate on your CV, how many grants you



believe you're actively involved in today. Approximately, doctor.
A. I still have to think about that.
Q. Well let me see if I can --
A. What -- what does -- what does "actively" mean? As the chairman, I theoretically have to sign off on every grant in the whole department, so my -- my signature goes approving every grant. So what is "actively?" Is that that I'm personally one of the investigators? Is that --
Q. Well let's start with that. How many grants are you the principal investigator on today?
A. Probably about four or five.
Q. And how many grants are you not the principal investigator on for which you have any kind of regular, consistent, active participation?
A. "Regular," how is that defined? Is it on a weekly basis or on a quarterly basis?
Q. I gave you three adjectives, doctor. You can define it how you wish. I said regular, --
A. On a week --
Q. -- consistent or active.
A. On a weekly basis about -- what I said first, about 20 to 25, and on a quarterly basis, if we include all the other multicenters, another 20.



Q. So let me ask you --
Let me read you something, ask you if this would be accurate or inaccurate. "Dr. Mont actively participates in many research studies in the area of joint preservation arthroplasty with over 100 grants."
Based on your testimony a moment ago, I guess that's inaccurate; right, doctor?
A. How --
Can you explain to me why you think that's --
Q. Do you actively participate in over 100 grants today? Based on your testimony a minute ago, I presume the answer is no.
A. The second part of that question says that I've had over 100 grants. I probably have had over 500 grants.
Q. Maybe I mis --
A. No, no, no. I've had over 100 grants because it's not my grants.
Q. Doctor, maybe I -- you misunderstood the question. I'll read it again. "He actively participates in many research studies in the areas of joint preservation arthroplasty with over 100 grants."
Do you actively participate in the preservation arthroplasty -- I'm sorry -- in the areas



of joint preservation arthroplasty with over 100 grants as we sit here today?
A. Depends on how you interpret. The way you're interpreting it, it's wrong. It doesn't mean I have a hundred at this moment, that says I've had -- I've had over a hundred grants. That's the way I interpret that sentence.
Q. Well why don't we do this, doctor. Why don't you tell us -- tell the members of the jury who may read this or see this videotape what an active, average, typical day is like for you on a typical week in your practice. What do you do in a typical week? Take it however you want, day by day, week by week.
A. Okay. For the jury, each one of my days is very uniquely different, so in answer to that question, if we really want to hear about what I do -- and I'm happy to disclose this. I actually enjoy what I do and I have a lot of observers that visit me and spend the whole day with me, and I enjoy sharing what I do with them, so I don't mind sharing with the members of the jury what I do.
On a Monday morning I get in around 7:30, it's my late day, and I go over some of the work that needs to be done with my research team, and it sort of sets the pace of what we've done over the weekend and

what we're going to try to do over the weekend. It's the beginning; it doesn't end that part.

At 8:30 there is a research conference that goes for two hours where two pages of -- of very active grants are -- and proposals and studies are gone over. I'm always there for at least the first hour of that conference. And there are about 25 people in the -- in the joint replacement -- it's a joint replacement research-specific conference. We go over all the studies that we're presently doing. I also have -- one of the residents is spending the day with me every Monday, so they're also seeing what we do in a -- from a research end and how somebody can meld in a clinical practice with research. The main things that I do first in the first hour are going over the 20 to 25 grants that I'm directly involved with that I mentioned earlier at any particular time. In addition, there are about 20 grant proposals or things or grants in evolution, grants that were just finished, studies that were just finished; those are the ones that I absolutely do. If there's -- sometimes I go into the second hour and I work through a lot of the other studies that I'm not directly involved with that I can give advice. Sometimes those conferences are used for other things like how to



prepare a grant. I just gave a lecture on how to write a research paper. That was two weeks ago. I spent 30 minutes teaching this whole group of 25 residents/research fellows how to do that. That's my 8:30 to 9:30.

At 9:30 I then meet with another team and I go over all the clinical cases that I will be doing for the next month to six weeks. So we go over all the patients and all the x-rays, and we look at the schedules for the operating room over the next four to six weeks. So that's an ongoing conference that happens every morning with my PA, my nurse practitioner, sometimes my administrative assistant, a clinical fellow -- not a research fellow -- and myself. That goes on until 10:30.

Around 10:30 I come back and look and see if there's any other issues that my administrative assistant has for the next 30 minutes. It actually --

Q. We're still on Monday; right?

A. We're still on Monday.

And it involves this list that is in my hand that you're seeing. Right now this is a list of 108 items. When I started this past Monday the list was about 76 items. About half of them have to do with any one of the 80 orthopedic attendings in my



department, which is my major priority as the orthopedic chairman. I have the focus on the different orthopedists that are not only on the main campus of Cleveland Clinic, but we have seven other hospitals in the region that are under Cleveland Clinic. So we go over that until about 11:00.

At 11:00 a clinic starts. The clinic encompasses about 20 to 30 patients; a little bit variable. I'm doing that clinic typically with my nurse practitioner, my PA, a fellow, and then as I mentioned earlier, I have a visiting resident every Monday -- Monday morning that's seeing my life.

I'm seeing patients. In between seeing patients there are gaps. I'm also doing reviews. I have -- there are anywhere from three to seven research fellows that are working for us. They are all, in the midst of that, showing me different things they're working on, different paragraphs they want to -- me to look at, handing off manuscripts. I'm doing reviews. I'm a major -- I'm the assistant editor or the number-two editor for Journal of Arthroplasty, which is the major arthroplasty journal -- or one of the major if not the major arthroplasty journal in the world. I do all my reviews that morning for that day, which is usually



five to 10. In the midst of it I'm handling --

Q. You see patients all this time; right? All in the midst of this.

A. I'm seeing patients. I do not hem and haw on any patients. I give them all the appropriate amount of time. If the patient needs 15 minutes, they get it. If they need an hour -- hour, they get it. If a clinic --

Q. It's your testimony for this jury today that you see patients for up to an hour?

A. I've seen patients for longer than an hour. In addition --

Q. On a regular basis.

A. On a regular basis every week. There's no week that goes by that I haven't at least one or two patients I've spent an hour with them.

Q. Doctor, that's pretty tough to do if you're seeing, at the time you left Baltimore, you said, 6,000 patients a year; right?

MR. C. GORDON: Object to the form of the question.

Q. Pretty tough to spend an hour with a patient when you're spending -- seeing 6,000 patients a year; isn't it?

MR. C. GORDON: Same objection.

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A. I see plen -- not only to -- not only to --
Q. Do you see patients on weekends, doctor?
A. You're not letting me answer the question, you're just ask --
Q. It's a -- it's a "yes" or "no" answer.
MR. C. GORDON: No, it isn't, and he doesn't --
A. Well I --
MR. C. GORDON: -- need to answer your question "yes" or "no."
Q. Doctor, do you work on weekends? Do you see patients on weekends?
A. I'm going to answer three questions ago. You can read it back.
Q. Just -- just --
I withdraw the prior question. The question on the table --
A. I'm not -- I'm not -- I'm not going to --
Q. Doctor --
A. -- I'm not going to let any -
Q. Doctor, I can withdraw any question I want.
A. Well I'm going to answer the way I want about seeing patients.
Q. The next question, doctor. The question is --

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A. The -- the number -- the number one thing I do is I take care of patients.
Q. Doctor, I'm not going to allow you to answer questions not pending. If I withdraw a question, we move on. It's my deposition. Now we can get an instruction from the court if you want.
The question is: Do you see patients on weekends? That's the question I want an answer to right now.
A. I speak to many patients on weekends, so in -- I just --
Q. Do you see patients in clinic on weekends, doctor?
A. I don't physically see patients on weekends.
Q. Okay. So can we agree that you see patients Monday through Friday?
A. And if the -- if the visit is not done, then there are calls, and I might spend a half hour to an hour and a half talking to patients on weekends over the phone, which is a continuation, theoretically, of the visit that occurred in the weekday, --
Q. Okay, doctor --
A. -- and it gets recorded as such. And I have lists similar to this of weekend phone calls --
MR. B. GORDON: Objection, --

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A. -- of continuations of visits --
MR. B. GORDON: -- non-responsive, --
A. -- on weekends.
MR. B. GORDON: -- move to strike.
Q. Doctor, you have clinic during the week. Are there certain days between Monday and Friday that you have clinic where you see patients and certain days when you do surgery?
A. Yes.
Q. Can you tell us what days those are.
A. The primary days I see patients are Monday and Tuesday on main campus, and every other Friday at another hospital called Euclid Hospital -- that's E-u-c-l-i-d -- I see patients in the morning on that day. I also see patients, theoretically, on any of the other days, Wednesday and Thursday. Or the other days there will be patients that on a special basis will come in. I will -- I am --
If any patient had a complaint about any provider, I -- I'm the first person to offer that I'm able to see them. Some of those are the patients that I -- that had a problem with a provider before me, are the ones that I spend an hour and a half with just to try to make sure every one of their needs are taken care of. I feel like that's part of my role.

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We also see sometimes X -- no. We -- we see various --
Strike that.
MR. B. GORDON: Objection, move to strike, non-responsive.
Dick, could you read back my last question, please.
(Record read by the court reporter.)
Q. So doctor, I'm going to clarify that question and break -- break it down and make it simpler. What days do you do surgeries?
A. The primary days I do surgery are on main campus on Wednesday and alternating Thursdays, more or less. I do surgery at Lutheran Hospital -- L-u-t-h-e-r-a-n -- and that alternates Thursdays with Euclid Hospital, but in any given week I might -- that can change depending on OR availability, so there are some weeks I've done surgeries at Lutheran on a Tuesday and had a full day. In addition, on the main campus I may squeeze a case in at the beginning of a day or at the end of the day on any of the days of the week.
Q. So on average, based on that answer, one or two days a week you do surgeries between those two hospitals?

A. No. On average I do two surgeries -- two days of surgery a week.
Q. Okay. So let's go with two days of surgeries a week. And based on Exhibit 4, your curriculum vitae, you perform greater than eight to nine hundred surgeries per year; is that right?
A. We've -- we've already answered that question --
Q. No, sir. I asked you about visits, not surgeries. I'm asking about surgeries now.
A. I already answered your questions about surgeries before.
Q. I don't believe so, doctor.
Let me ask it again. You do greater than eight to nine hundred surgeries per year. That's your testimony?
A. That's not my testimony. I already answered this question.
Q. It would be pretty difficult to do eight to nine hundred surgeries -- or greater than eight to nine hundred surgeries if you did surgeries only two days a week; wouldn't it, doctor? It would be impossible; --
A. Yes.
Q. -- wouldn't it?



A. No, it would not be impossible.
Q. All right. Well let's do the math. If you did surgery all day, --
A. Yes.
Q. -- which I don't believe you testified you did it all day, in some cases I think you said you squeeze in a case at the beginning of the day or the end of the day, but let's say it's all day two days a week. How many surgeries would you have to do those two days to do 900 cases a year?
MR. C. GORDON: Object to the form of the question, move to strike counsel's commentary and testimony.
Q. Have you done the math on that, doctor?
A. Easily. If --
Twenty times 50 weeks is a thousand cases, so you -- you could do 10 each day two days a week and you get 900 cases.
Q. Is it your testimony that you do 10 surgeries a day two days a week?
A. When that was written I did more than 10 surgeries in a day, 10 or 11 or 12.
Q. And on those same days did you see other patients, doctor?
A. On those days, occasionally there might be a



patient that I would squeeze, but generally, no.
Q. Well to do six --
A. In those days.
Q. In those --
A. In those days.
Q. In those days you did 6,000 patient visits a year you said; right?
A. Correct.
Q. To do 6,000 patients Monday through Friday --
There's 260 weekdays in a year; right, doctor?
A. I didn't work 260 weekdays in a year. There were --
Q. How many did you work?
A. I'd have to recalculate it. If you want, I'll give you --
Q. Well --
A. -- an exact answer.
Q. -- let's just say at 260 days, if you did -- if you saw patients every day -- weekday of the year, that would be 23 patients a day every single day of the year, 260 weekdays a year. Did you see 23 patients a day every single day of the year when you were at Baltimore, separate and apart from your



surgeries?
A. I saw more --
Your numbers are not an accurate reflection. I saw easily 150 -- 125 to 150 patients on a regular week every week. If you did the math times 40 weeks, that would be 6,000. There were some weeks -- as I told you, these become irregular -- that I threw in an extra clinic and we'd see another 60 or 70 patients. So that's what I did.
Q. And you did that while giving conferences, nationally and internationally; right, doctor?
A. You're -- you're -- I --
I've always given conferences nationally and haven't done as much internationally, but I do, yes, I do internationally.
Q. Do you take any vacations?
A. I take vacations.
Q. Do you do trips to work for your -- how do you pronounce it -- Molluscan or Molluscan Corporation?
A. Okay. If your implication is that you think that I can't do all these things that I say on my CV, I think you're mistaken. I think -- I don't like --
Number one, I don't like the implication. I give -- my number-one thing that I do is my patient

care for the patients. I give every patient -- every patient I've ever operated on has my cell phone number. Any visit that -- is rechecked that the patients have adequate time for everything; if they don't, they're brought back even the same day. I continue this as virtual visits on the weekend. I speak to them. So the implication that I don't have enough time to do -- or that I'm not doing what I'm saying is incorrect, that there is plenty of time in the day to do what I'm doing. The math you're describing is not correct. You're -- you're averaging --

Q. The math doesn't work; does it, doctor?

A. The math doesn't work the way you have it. It -- it -- one hun --

It more than works for me.

Q. Doctor, it's impossible to see 6,000 patients in a year five -- if you -- if you see them on clinic days while you're still doing surgery and do anything else the rest of that year, to travel, you're at conferences --

A. Your implication is that I'm seeing --

Q. It's impossible.

A. -- all the patients while I'm doing surgery, and that's incorrect and that's out of context. And



you're -- you're implying that I do something like that, and I don't do that.

Q. Well the fact is in a lot -- a lot of the surgeries you don't even show up and do the surgery, you have your residents do surgeries; isn't that right?

A. And that's incorrect.

Q. All right. Let's talk about your patients. You -- you said you have this great relationship with your patients, --

A. Okay.

Q. -- you give them your cell phone number. Let's talk about that.

A. Okay. You can't make statements --

Q. Do your patients tend to like you, doctor, do you think?

A. Yes, they do.

Q. Okay. You think you have a good bedside manner? Do your patients tell you that?

A. Yes, they do.

Q. All right. Let's talk about some of them. You -- you --

Have you seen the reviews your patients give you, doctor?

A. Yes.



Q. Let's read one from May 20th this year, just a couple of months ago. "Disappointed that Dr. Mont doesn't even come by post surgery to see his patients."

Let's look at another one a month before. "Very impressed with everyone and everything at the hospital except Dr. Mont. He could listen better. I felt rushed with him. I know he's a good surgeon so I drive three and a half hours to see him, maybe he had an off day, but his bedside manner leaves a lot to be desired."

Let's look at one from January. "The doctor never even came by to see me after my surgery."

Let's look at another one from March of this year. "I was a patient of Dr. Mont's in Baltimore. He has a terrible bedside manner. Total knee replacement came out terrible. I never even saw him after surgery."

December 2016: "Dr. Mont's residents did my total knee replacement in 2008 even after telling me he did the whole surgery."

MR. C. GORDON: Object --

Q. Doctor, the list goes --

MR. C. GORDON: Object -- strike -- excuse me, doc.



THE WITNESS: That's okay.

MR. C. GORDON: Object to the form of the question, move to strike counsel's testifying.

If you've got a document you want him to review, please show it to us, but you're just throwing out random comments --

A. You want an answer to this?

MR. C. GORDON: -- and it's inappropriate.

Q. Doctor, --

A. Is this a question --

Q. -- I should ask you a question.

A. -- or is this a statement?

Q. Let me ask you a question.

THE REPORTER: Let's go off the record.

(Discussion off the record.)

BY MR. B. GORDON:

Q. Doctor, for the record, when counsel objects, I'll try to stop if you'll try to stop. We need to both let him get his objection on and then I'll ask you a question.

I was reading those statements to lay a foundation for the question I'm going to ask you now, and the question is: Have you seen patient reviews like the kinds I just read, of which there are many, that describes you as having a terrible bedside

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manner?
MR. C. GORDON: Objection --
Q. Have you seen those?
MR. C. GORDON: Same objections, also lack of foundation.
Q. Have you seen those, doctor?
A. I've seen hundreds and hundreds of my reviews. The greater-90-percent preponderance are very positive. And there are certainly -- you read one from 2008 that was negative and there's certainly -- any practitioner has negative reviews, and we can find that for not only myself, for any practitioner. And there can be a response to each one of the ones that you read. And fortunately, the preponderance of my reviews and my ratings in the past and where I am are very -- are extremely high.
Q. Doctor, the review I read, just so it's clear to you, was from December 12th of 2016 and it referred to residents doing surgery for you in 2008 in Baltimore. It wasn't from 2008. But let me ask you a question since you mentioned that.
Would it surprise you that I found 35 reviews of you within the last seven months that are of the same type, talking about how bad your bedside manner is?

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MR. C. GORDON: Object to the form of the question, lack of foundation, move to strike counsel's commentary and testimony.
Q. Would that surprise you, doctor, 35 bad reviews?
A. You might have 3500 great reviews.
Q. All right. Let me ask you this: Have you ever been involved in a lawsuit, doctor?
A. Yes.
Q. How many?
A. I don't know the exact number.
Q. You've been sued a number of times; haven't you?
A. Yes.
Q. For medical malpractice; right?
A. Yes.
Q. Any of those still pending?
A. I think there may be -- there might be one. I'm not sure where it is.
Q. Okay. So is it fair to say in the last nine years you've been sued at least 11 times? Would that surprise you?
A. Potentially. That's possible.
Q. Okay. You don't disagree with that number.
A. I don't know the exact number, but I

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wouldn't disagree with it.
Q. Okay. Doctor, I want to follow up on that question about the lawsuits. Have you had any verdicts rendered against you by juries?
A. I don't know if it's against me or the hospital.
Q. Cases where you were a defendant.
A. I don't --
I'm going to answer the same way: I don't think it's against me personally, or if it is, it's -- I don't know the semantics of it.
Q. So it --
A. I've been -- I've been told by the hospital that it's -- if there are settlements, that it's not against me personally.
Q. You are aware that --
MR. C. GORDON: I -- I just want to --
You and I know the difference between a verdict and a settlement. You were asking just about verdicts; right?
MR. B. GORDON: I was in that question. I'll clarify.
Q. So in that last question I was asking about verdicts where a jury or a judge decided against you. So have there been any cases that you're aware of

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where you've been a defendant that a judge or a jury has issued an award against you?
You're shaking your head. Is that a no?
A. I don't think any jury or judge, to the best of my knowledge. I could be mistaken.
Q. Okay. So you're not sure.
A. I'm pretty sure no. I haven't --
I've only gone to jury once. Yeah, I've only been in jury once. Of all these -- these 11 cases, it's only gone to jury one time.
Q. Okay.
A. And it was -- and it was, whatever the term, hung jury.
Q. And the other cases have all been settlements, to your knowledge?
A. To the best of my knowledge, yes. Or -- or dropped.
Q. Or what?
A. Or dropped.
Q. Dropped. Okay.
Do you have any lawsuits that you filed against other physicians?
A. A lawsuit that I filed against a physician?
Q. Where you were a plaintiff and another doctor is a defendant.

A. No.
Q. None?
A. Not --
I mean maybe I'm forgetting something, but I don't remember suing --
Q. Well let's be very clear. It's your testimony before the jury in this case that you've never filed a lawsuit against another doctor in Baltimore.
A. Well, it's a question I haven't really thought about or asked. Have I ever filed a lawsuit against another doctor?
Q. Who is Martin Binstock?
A. Oh. Well that's not a doctor. I mean that would have been in a lawsuit that was against Good -- my former employer, Good Samaritan Hospital, so I don't know how that was framed.
Martin Binstock was the -- one of the higher executive office -- officers at Good Samaritan Hospital. If he met me now he would give me a hug. So if the lawsuit in name was -- it was a -- I left --
So the details of what your implication is, I left Good Samaritan Hospital, which was -- I was part of Johns Hopkins Medical Institution, and I went to Sinai Hospital around 2000 -- you can see that in



my curriculum vitae -- vitae, which that's correct -- and then there was an issue of pay that was -- that I felt that I deserved that wasn't given to me, so there was a lawsuit against Good Samaritan Hospital for payments of the last six months or whatever it was, it might have been -- I don't remember the details of it, which I eventually won. So if Martin Binstock was part of that lawsuit, it was probably only his name as representing Good Samaritan. I wouldn't know that his name was on that.
Q. Okay. My question, just to be clear, was who was Martin Binstock, and that was your answer; right, doctor?
A. Well I was trying to clarify, because to me it came out of nowhere, because Martin Binstock and I, when I've seen him maybe five to seven years ago, are in a great relationship, and I don't think that he would view with me as suing him or --
Q. So you and he --
A. -- relate that.
Q. -- have mended fences.
A. I don't think we didn't ever have mended fences. I think he was disappointed that I left Good Sam, but he understood some of the reasons.
Q. Doctor, let's talk about your report. Do



you have Exhibit 5 in front of you, which I think is your report in this case?
MR. B. GORDON: Let's take a five-minute break.
THE REPORTER: Off the record, please.
(Recess taken.)
BY MR. B. GORDON:
Q. Doctor, I'm going to ask you, for purposes of the court reporter and the judge and the jury who have to read this transcript, probably, or look at this videotape, would you try to meet me halfway and listen to my questions carefully and try to limit your answers as much as you can?
MR. C. GORDON: Object to the form of the question.
Q. Would you do that for us?
A. I will do the best I can.
Q. I appreciate that much very. Thank you, doctor.
Let's look at your report. Do you have your report in front of you?
A. Yes, I do.
Q. And that --
We've got that market as Exhibit --
MR. C. GORDON: Five.



Q. -- 5, right? Okay.
A. Correct.
MR. B. GORDON: Real quick before we do that, your counsel was kind enough to provide us with some invoices, and I'm going to show you two documents and have those marked as the next two exhibits in order, one from May 16th, 2016, the next from July 10th, 2017, and we'll mark those as, I think, six and seven respectively.
(Exhibits 6 and 7 were marked for identification.)
(Discussion off the stenographic record.)
BY MR. B. GORDON:
Q. So doctor, do you have Exhibits 6 and 7 in front of you?
A. Yes, I do.
Q. Have you had a chance to look at those?
A. Yes.
Q. Those appear to be all of the invoices that you submitted to counsel for your work in this case.
A. No. No.
Q. So there are --
A. There may -- there may be an April 2017 invoice. And --
Q. All right. And I apologize. So you think

we may be missing an April of 2017 invoice?
A. Well I don't see it here.
Q. Nor do I. So bear with me just a minute, doctor. I thought I had everything.
MR. ASSAAD: Here, it's on the last page.
MR. B. GORDON: Oh.
Q. So if you will, doctor, look at the one we've marked as Exhibit 6. The third page of that is May of 2017 for work that was presumably submitted, it says, April -- it says "MICHAEL MONT, APRIL INVOICE 2017." Is that the one you're referring to?
A. Yes.
Q. Okay. Let me ask you about that one first. Setting aside the first two pages of that exhibit, which relate to work you did for science day, as I understand it --
Is that right, the first two pages?
A. I haven't looked at this lately.
Q. Let me ask it this way.
A. Please ask the question again.
Q. Yeah, let me ask it this way. On page --
On Exhibit 6, the first two pages are dated two different dates in May of 2016; correct?
A. They're May 16th, May 24th, 2016, correct.
Q. So given that fact, that those are 2016,



would that refresh your recollection that this work related to the time you spent on science day --
A. Well --
Q. -- in preparation for --
A. Yes. And also reading the actual invoice, it says "Rehearsal day," so that sounds like the day before.
Q. Right. Yeah. Let's talk about that. The one you're talking about at the top of the beginning of the first page of Exhibit 6, you -- you've got a couple of things that mention "Dry run with Peter Goss" --
What was that about?
A. I don't --
I'd have to really wrack my brain to remember exactly, but it probably was just going over some details of what I was presenting. So on the science day I made a presentation, which you were there for, and it would have been -- is this the correct -- there was a multitude of material that could have been presented. I had to know exactly what was -- lot of details, my time limit, what are the details to be put into that presentation, et cetera. So that -- that answers your question.
Q. So what does "dry run" connote to you,



doctor?
A. This is what I'm going to present at this -- close --
This is what I'm proposing to present at science day to another party.
Q. And so that, to the best that you can describe it for the jury, was about an hour you spent with Mr. Goss where he -- just sort of a mock examination of you for science day?
A. I don't think he did an examination. I think I just gave him my presentation, and he critiqued how I did.
Q. And then --
MR. C. GORDON: Ben, I need to impose --
You can ask questions, but I want to put --
MR. B. GORDON: I'm asking a question.
MR. C. GORDON: -- put an objection on the record. But yeah, science day was, per the court, off the record, and I mean it was not -- so --
MR. B. GORDON: I'm not asking the substance. I won't get into the --
I'm almost done here.
MR. C. GORDON: Okay.
MR. B. GORDON: Thank you. I understand that, Corey.



Q. And then the other thing you mentioned was, quote, "Rehearsal day, 4 hours," so that was half a day that you spent rehearsing what you were going to do at science day; is that fair?
A. Yes.
Q. Okay. Let's turn to page three of Exhibit 6, and this is your April invoice from 2017, April of 2017; correct?
A. Oh. Yes.
Q. And one of the --
A. Sorry. So --
Q. Sorry.
A. Yeah, I see now. That's true.
Q. Here's my question. Yeah. So we've got the one you -- you thought was missing, and so one of the things I note on here is that about one, two, three, four -- five lines down you say "Initial Review Jarvis report, 30 minutes." Do you see that?
A. Yes.
Q. Is there anywhere that you have time for additional review of Dr. Jarvis's report?
A. I don't -- we can look at it. You can -- if you know I didn't, I can --
Do you want me to look at the May and June --

Q. Well --
A. -- invoice?
The answer is, just as a general, there are a number of reviews. This is probably understated, some of this. I did a lot of reviews. Sometimes I didn't record when I looked at something for 10 or 15 minutes -- or 10 minutes or 15 minutes, I just --
So -- so these -- these are known time periods that I took out, recorded it. There are other times I didn't record it. The Jarvis report was something that -- that to me I looked at, I scanned it, I spent some time on it, and I put "Initial Review" because my brain said potentially I'll come back to this and put a lot more detailed time into it if I think I need it.
Q. And that's really my question, doctor. This -- this says "Initial Review." Doesn't that denotatively imply there will be more review of Dr. Jarvis's report? Doesn't it?
A. Potentially.
Q. Okay. Was there? Have you done any more?
Let's look at Exhibit 7 --
A. I -- I think --
Q. -- if you want to.
A. I think that --



Q. Have you spent any more time on Dr. Jarvis's report as far as anything reflected --
A. I think --
Q. -- in these two invoices?
A. I would say less than 10 minutes.
Q. Okay. And let's look at --
A. But I have spent --
I probably wouldn't have put that into these invoices.
Q. And let's look at Exhibit 7, which are your July and June -- dated July and June but actually your June and May invoices. You see those?
A. Yes.
Q. And, for example, in the first page dated July 10th, reflecting your June invoice from 2017, the second line you have "Review Richard Wenzel report, 3 hours."
Who is Richard Wenzel?
A. He is one of our experts.
Q. One of your experts. One of the defense experts; right?
A. Yes.
Q. He's a defense infectious disease doctor; right?
A. Yes.



Q. And Dr. Jarvis is the plaintiffs' infectious --
A. Yes.
Q. -- disease doctor; right?
A. Yes.
Q. And you spent three hours on Dr. Wenzel's report just in this one statement; correct?
A. Correct.
Q. And only 30 minutes plus 10 minutes you said on Dr. Jarvis's report; correct? My question --
A. Yes.
Q. My question is: Is that correct?
A. Yes.
Q. So in your mind, before this jury under oath, is it your testimony that you put six times more emphasis and importance on Dr. Wenzel's report as Dr. Jarvis's?
A. Incorrect. And the explanation is that since I'm sitting here, I don't --
There's a lot of different reasons for that. One of the reasons would be if he is covering certain topics as part of this defense, then I would want to know what he's saying very precisely; I wouldn't want to nec -- number one, I wouldn't want to necessarily replicate what he's already doing. There are --



number two, there are degrees of expertise that people have. I'm supposed to be an expert on orthopedics but I also -- my expertise runs past orthopedics in a lot of different areas. He's an infectious disease expert. I have to know infectious disease. I write a lot of papers and reports on infectious disease, but I certainly want to know what -- his opinions and where -- what topics he might be talking about --
Q. Dr. Wenzel you're talking about.
A. We're talking about Dr. Wenzel.
Q. But not Dr. Jarvis.
A. Well I'm --
Q. He's an infectious disease doctor too; right?
A. Well I glanced at what he --
Q. He was with the CDC for 23 years. Are you aware of that?
MR. C. GORDON: Object to the form of the question.
A. He mentioned something like that.
Q. Do you not --
A. On science -- science day he mentioned some --
Q. Do you not recognize Dr. Jarvis as a leading authority in the world on infectious disease?

MR. C. GORDON: Object to the form of the question, lack of foundation.
A. I don't -- I don't recognize one way or another.
Q. Okay.
A. So it would be in his report.
Q. Have you talked to Dr. Wenzel about Dr. Jarvis?
A. I'm not sure. I can't ans --
Q. Have you talked to Dr. Wenzel?
A. I've talked to Dr. --
Yes, I have talked to Dr. Wenzel.
Q. Have you asked him what he thinks about Dr. Jarvis?
A. I don't remember.
Q. Would it surprise you that he thinks Dr. Jarvis is one of the leading authorities on infectious disease in this country for sure?
MR. C. GORDON: Object to the form of the question, assumes facts not in evidence.
Q. Does that surprise you?
A. I'd have to think about the answer and --
Q. Okay.
A. -- go over it.
Q. That's fine. You think about it. We'll



come back to it.
A. The ans -- the question --
Does that mean --
Q. You think about it.
A. -- at the present time or back in the '90s --
Q. Well --
A. -- or something like that?
Q. -- think about it and we'll come back to it.
Let me ask you this: So you said it was incorrect when I asked you if you thought Dr. Wenzel's report was six times more important to you than Dr. Jarvis's, so that means Dr. Jarvis's report is at least somewhat important to you?
MR. C. GORDON: Object --
Q. How would you characterize it?
MR. C. GORDON: Object to the form of the question.
Q. Is it one-half as important as Dr. Wenzel's, a third?
MR. C. GORDON: Object -- object to the form of the question.
Q. Well you would say it's not as important as Dr. Wenzel's because you spent one-sixth the amount of time reviewing it. Is that fair?



A. It doesn't -- it doesn't ascribe the importance. Time spent on something doesn't ascribe whether -- a quality of importance or a rating of importance or not. Some things that are important you might spend five minutes on because you know it or you see it, other things that you find unimportant for opinions, you might spend a lot of time on it. So I've never thought of it that way and I don't necessarily agree with that.
Q. Isn't it true, doctor, that you had your mind made up when you came into this case that you thought the Bair Hugger was a perfectly safe device? Isn't that correct?
A. When I -- when I came into this case? No, --
Q. Right.
A. -- that's not -- that's not how I felt.
Q. You didn't come into this case with the preconceived belief that the Bair Hugger device was a safe and effective device to use in surgery? Is that your testimony before this jury?
A. The best answer is that I came into --
I believed that the Bair Hugger was safe because it was used at the hospital that I was at and has continued to be used --



Q. And that was before you were retained in this case; correct?
A. Yes.
Q. Okay. Thank you. Let me ask --
MR. B. GORDON: I'm going to mark some additional exhibits, doctor. I want to mark next in order the exhibits that you had to your report, and I'm going to -- we're going to call these 8, 9, 10, 11, 12 and 13, in the order that I'm going to hand them to the court reporter, and then we'll talk about them.
Hopefully that works, Dick.
(Exhibits 8 through 13 were marked for identification.)
BY MR. B. GORDON:
Q. So doctor, I'm going to do my best to describe these and then show them to you and --
(Witness texting on cellphone.)
MR. B. GORDON: Do you need to take a minute?
THE WITNESS: I'm okay.
MR. B. GORDON: Okay?
Q. No. 8 I'm going call what you list as "EXHIBIT A - REFERENCES AND MATERIALS CONSIDERED" and ask you if that sounds like a fair description of that

document.
A. Yes.
Q. And No. 9 -- thank you.
And No. 9 is entitled "Mike -- Michael A. Mont 6/1/2017 Depositions and Trials," and this appears to be a list of your testimony going back to 2013 in other cases. Does that look right?
A. Yes.
Q. Thank you.
No. 10 is a photo compilation of something entitled "Sources of Heat in the Operating Room;" correct?
A. Yes.
Q. No. 11 is a document entitled -- looks like an abstract, a medical abstract entitled "HEPA Filters Do Not Affect Infection Rates Following Primary Total Joint Arthroplasty With Forced Air Warmers;" is that correct?
A. Correct.
Q. No. 12 is a stack of photographs -- some of which I think you presented at science day, but you tell me if I'm wrong -- and it starts out "Bair Hugger Blanket" and looks like it's a depiction of an operating room setting with you on the table, if I'm not mistaken. Is that right?



A. That's not correct.
Q. That's not you.
A. That's not me.
Q. Okay.
MR. C. GORDON: Were those -- were those the attachments to his report?
MR. B. GORDON: Yes.
MR. C. GORDON: Okay.
MR. B. GORDON: Yeah.
Q. These all have been attachments to your report, so that's --
A. Way younger person. I wish it was me.
Q. Okay. So -- so that's --
It's fair to say, though, that's a --
A. No. I don't know --
Q. -- re-creation of an actual patient.
A. I don't -- I don't -- I don't know who that is.
Q. But is it a patient, or is that a mock setup?
A. I believe --
To the best of my knowledge this is a mock setup because you're seeing a patient -- I mean you're seeing a per -- an individual on a table, and the way the leg is prepared is not -- for modesty issues



there's -- there's a thing there, and that's not the way you would --
So I think it's -- it's just a -- it's a mock demo with a model. I don't know who the model is.
Q. Okay. I guess my question is: As to all of those photos -- and there's one more that we've marked separately as Exhibit 13 entitled "Common Sources of Bacteria in Operating Room" -- and I guess with respect to all of these, did you prepare these photos and these representations of the operating room setting?
A. Inso -- insomuch as I might have helped pick -- I -- I didn't -- I didn't -- the --
The true answer is I didn't -- didn't physically prepare it, like I copied this or I did this, but insomuch as I had input on which of these pictures were selected, the answer is yes. If that answers your question.
Q. It does. Let me ask a followup question. You --
Did you supervise the representation of mock surgical settings that are depicted in these photos, or at least some of these photos?
A. I wouldn't say "supervise." I was part of



the team that discussed and selected these. I -- I --
Q. Who else was on that team?
A. I would say Corey Helton.
Q. Corey Helton. Who is that?
A. Corey.
Q. Oh, Corey Gordon.
A. Corey Gordon. I'm -- not Helton. I'm thinking --
Q. Who is Corey Helton?
A. -- of a baseball player.
Q. Oh, okay.
A. I'm sorry. I'm a baseball person.
MR. C. GORDON: He's a baseball player, Corey Helton?
THE WITNESS: Yeah. Yeah. Anyway, my -- I -- I --
Q. Okay. So counsel helped put these together; is that fair?
A. Cor --
Yeah, Corey Gordon and counsel. And let me think. Is there anybody else that helped us put this together besides --
Q. Any other non-lawyers involved, any like nurses or doctors?
A. I wouldn't know if Dick Wenzel inputted on

that or not, or somebody like that. So basically it was me and the counsel team.
Q. Who are the people depicted in some of these photos? Are these staff that work for you?
A. No. I don't know who these people are.
Q. You don't know who those people are. Okay. And you're aren't physically --
A. I may -- I may have at one point known where this --
This might have been a demo that was done. This potentially is something that is on YouTube and these were pictures from them, or it may have been there was -- maybe it's a -- it's a lab in Florida or a lab in Minnesota. But --
I may have known the answer to those questions earlier, but I don't -- as we're sitting here today --
Q. Okay.
A. -- I don't know where --
Q. You kind of anticipated my followup question. You don't know as we sit here today with certainty where those operating rooms or mock operating rooms took place.
A. I'm sure --
If you want, I'll -- we -- I can find out



later. We can ask.
Q. Yeah.
A. I believe I would try to figure out, if you want.
Q. Yeah. And if you figure it out in a break --
A. Let me --
Q. -- and you want to tell us later, then that would be --
A. No, no. Well I'd have to go and do a little research in the break, if that's what you want me to do.
Q. Well I don't want you to take time away from your testimony here today, doctor, but certainly at some point between now and the time of trial we'd like to know, if you know, where those operating rooms were, who set them up, and who the personnel are depicted in those.
A. Okay. So where they were --
Q. Who -- who supervised or set up the --
A. Who set up.
Q. -- representations and --
So where they were, who's in them, who set it up. Who, where, what.
A. Okay.



Q. All right. Thanks, doctor.
Now we'll set those aside for the moment and come back.
And let's go back to your report, which was Exhibit 5, and turn -- have you turn to page three where you start opinions. Okay? And let me ask you first: Are you familiar with Federal Rule of Evidence -- I'm sorry, Federal Civil Procedure 26 at all?
A. Can you say that again? Federal what?
Q. Federal Rule of Civil Procedure 26. You've heard that before; haven't you?
A. No, I have not.
Q. You've heard of a Rule 26 report. You've done a bunch of them over the years; haven't you, doctor?
MR. C. GORDON: Object to lack of foundation.
A. You may -- you may know better than me because I don't -- this is --
I'm not a lawyer and I don't know things like Civil Procedure 26. I try to --
Q. Okay. So you just don't know the term Rule 26 report. That's fine. That's fair.
The report you have in front of you, which



we've marked as Exhibit 5, is your complete report and the basis for your opinions in this case up to this point in time; is that fair?
A. I guess that's the report, and then I guess --
I don't know where you put the supplemental materials into that answer --
Q. Well let me ask you this --
A. -- but --
I guess that and the supplemental materials. But --
Q. You knew there was a deadline to issue your report in this case; right?
A. Yes.
Q. You mentioned June 1st or June 2nd; right?
A. Yes.
Q. And you -- you complied with that deadline; right?
A. Yes.
Q. And you did everything in your power, to the best of your ability, up through and including that date, to include everything in your report that you thought expressed your complete opinions in this case; correct?
A. Correct.

Q. And the support for those opinions; correct?
A. Yes.
Q. All right. So let's talk about some of those opinions.
On page three, the first opinion that you state, your number-one opinion is, quote, "The major source of periprosthetic joint infections (PJIs) is the patient's own skin;" correct?
A. Correct.
Q. So I want to know every single piece of support you can cite as the basis for that opinion. I need specific citations of authority for that narrow opinion.
A. I -- I don't think that many of these citations are of authority. This is a whole list of body of literature. To -- to call one authoritanian -- authoritarian is a misnomer.
Q. Well I didn't say authoritarian.
A. But I -- I -- I view this as more of --
(A person enters the deposition room.)
THE REPORTER: Go off the record.
(Discussion off the record.)
A. I'd say where to get that opinion, some of that to me is knowledge that I had as -- it's a working knowledge that I had when I first got



introduced to orthopedics as a resident. There are different documents from --
So it's a general knowledge from the CDC and different things. I think even Dr. Jarvis himself in the '90s wrote a document for -- that talks about sources of infection coming from the patient's skin and -- and body majority-wise. But I don't know which --
There's a whole bunch of articles that are listed here, 11. I don't know if it's every article that I wrote. I just put some of them that are dealing with the skin and decontamination. That's why I spent so much of my life -- no -- a -- a good portion of research -- my research life with studying skin decontamination. We were able to reduce infection rates by like 60 or 70 percent, sometimes even more.
Q. And -- and we're going to talk about that, but let me just take you back to this question right now, doctor. The -- the question we're talking about, top of page three, is your one sentence in bold, "The major source of PJIs is the patient's own skin." I just want to take you to that narrow question right now and ask you to look at Exhibit 8, I think it is -- yeah, Exhibit 8, which is your "EXHIBIT A --



REFERENCES AND MATERIALS CONSIDERED," and ask me what specific authority, if anything, on this list supports that statement.
MR. C. GORDON: On only --
You -- you want to limit him to what's on the reference list --
MR. B. BORDON: Well --
MR. C. GORDON: -- as opposed to what he specifically cited in that specific section?
A. This is in my report. There's 11 references.
Q. Well doctor, you have --
You're referring now to 11 references on pages four and five --
A. Correct.
Q. -- relating to chlorhexidine skin prep and control of the skin in an operating setting; right?
A. Skin infections, which is a direct answer to your question.
Q. And we're going to talk about that. But are you saying that these 11 sources specifically support the statement that the major source of periprosthetic joint infections is the patient's own skin?
A. Some of them say that.
Q. Okay.



A. I'd have to look at the references. Some of them mention that.
Q. And what these articles reference, do they not, doctor, is a process that you as a surgeon follow and other surgeons follow to try to prevent skin from having infective microorganisms; correct?
A. Correct.
Q. Okay. So you're trying to control for that possibility, that there might be microbes on the skin; right?
A. Correct.
Q. And so what I'm asking you now is a little different than, I think, and that is: Are there any specific authorities that say that notwithstanding that prep that you've done with the chlorhexidine that you've been so, you know, scrupulous about in these references, there are patient's own skin flora that still can cause PJI notwithstanding that chlorhexidine prep? Are there any specific references that say that?
A. I don't really understand the question.
Q. Well let me -- let me rephrase it.
A. You have to --
I don't understand the "notwithstanding" part.

Q. So you say, the beginning of page three, you know, your first opinion in this report --
In fact, it's in bold; right, doctor?
A. Yes.
Q. You put it in bold; right?
A. I wrote this report. Yes, I did it.
Q. You intended to emphasize this opinion; right? It's number one in your report; right?
A. I don't know if the ordering of --
Q. It's the first opinion in your report; isn't it?
A. But that --
I don't think the first is necessarily the most important.
Q. Okay. It's in bold; isn't it?
A. I -- I -- I just put a list of opinions. I didn't --
Q. All right.
A. -- I didn't put a value equation on which one is more --
Q. Well the jury can decide --
A. -- or less important.
Q. -- if they think it being first has any weight.
A. Okay.



Q. It's in bold. Does that give it some intended emphasis?
A. Well I --
Aren't all them in bold?
Q. Well just the --
A. Yeah, they're all --
A lot of the opinions are in bold. So this whole thing --
Q. So anything in bold you intended to emphasize; did you not?
A. No. They -- no.
MR. C. GORDON: Object to the form of the question.
A. The bold was to --
No.
Q. Okay. So --
A. The bold was to separate different, in my opinion --
The way I intended this report to be is that the bold was separating different concepts --
Q. Okay.
A. -- so that the reader could look at them with a little bit of ease rather than have a single 18-page opinion without separations. And what I could have done was number them, and what I could have done



in reference to your thing, which if I looked at this again I would have written something like "Here are my opinions numerically numbered, not necessarily in order of importance," which is what I usually do on reports.
Q. So the fact that this opinion is in bold and is listed first in your report has no weight in where it stacks among your opinions.
A. I -- I --
Q. Is that fair?
A. I apologize to you and to the jury for not making that -- which is in almost every record that I've ever done before, that the following are my opinions, usually numbered, and I say "not necessarily in order of importance or priority." That's in --
And if you looked at my last five hypes, or whatever opinion, they all have that same sentence. I don't know why this one didn't.
Q. So this is just one of your opinions; correct?
A. Yeah. And they're bolded just to -- they're bolded just to separate them.
Q. Yeah. Separate them but not emphasize them. I got it.
So let me ask you this: There's not a



single citation in that paragraph of any authority; is there? You mention the 11 citations --
A. Well -- well --
Q. -- two pages later, but is there a single citation of authority in that paragraph for that proposition?
MR. C. GORDON: Object to the form of the question, --
A. There's -- there's 11 --
MR. C. GORDON: -- mischaracterizes the evidence.
A. There's 11 citations after this section that are cited.
Q. One, two, three, four -- five paragraphs down there are 11 citations relating to a paragraph that begins about chlorhexidine prep.
A. Yeah.
Q. And all of those citations concern chlorhexidine prep; don't they?
A. No, I don't think so.
Q. Well they -- they all concern skin prep.
A. No. Number five says "Preoperative skin disinfection..."
Q. That's not skin prep?
A. Well okay, that is.

Let me look at the rest of this.
Q. Show me which one does not concern skin prep in some way. And the -- and the question I'm asking you about, --
A. Okay, so --
Q. -- your first opinion doesn't relate to skin prep, it's making the skin --
A. All right. So -- so I didn't --
I have published on prevention of perioperative infections. I didn't put it in those 11 references. To me it's a more common-knowledge statement. And I'm happy to provide you or the court and the jury with references to that opinion, but I didn't put it here.
Q. Okay. And now that's why I'm asking. Since there's not a citation on page three with respect to that first proposition, first opinion about the patient's own skin being the source of maj -- a major source of the PJIs, where in Exhibit A, your list of references and materials considered, do you -- do you find support for that proposition? Is there anything --
A. I'd have to go through the articles. And I believe that some of these --
First of all, some of these references would



support that proposition of these 11, because --
Q. Can you point to one?
A. I have to look at them, because some of them have it, some of them none.
Q. All right. Well as we sit here right --
A. Because when you write the paper, the first paragraph of the paper --
Q. Pretty important, first paragraph; right?
A. -- often might say that skin contamination is the major source of infection. It -- the first paragraph of many of these papers might say that. So even though you're saying -- and I hear you -- that the major topic is that -- that statement, that bolded statement, it -- that statement is very -- is in some of these papers, --
Q. You're -- you're --
A. -- or very similar to it.
Q. Doctor, you're familiar with the old adage "First impressions are lasting impressions;" right? I mean you intended for the first thing in this report to be --
A. No, I did not.
Q. -- important; did you not?
Okay. So it's not.
A. No. As a matter of fact, I didn't --



As you're pointing this out, if -- that may -- that may be good, but no, I didn't do it that way. I should have -- I just told you a few answers back that I should have said --
You know, I'm not the one to decide what are the major and critical issues of this case. I wanted to put all my opinions in.
Q. Who is the one to decide?
A. What?
Q. Who's the one --
A. I think the --
You.
Q. The lawyers?
A. Probably. You're --
Q. So it's --
A. You're the one trying the case.
Q. So it's not the scientists who should decide what the important issues in this case are?
A. Well let's -- let's -- then let's -- let's answer --
MR. C. GORDON: Object to the form of the question, lack of foundation.
A. -- that it's a team effort. But I'm not --
I'm only one member of the team and I just wanted --



Q. The rest of the team were lawyers.
MR. C. GORDON: Object to the form of the question.
A. No, it could be other experts like me, it could be the jury, it can be the judge, --
Q. It's not up to you --
A. -- it could be a whole team of people that are going --
Q. You said you came into this case with an open mind about the answer you were looking at, right, about the answer that you were trying to -- to derive in this case. What -- what was the question --
A. Answer, yes.
Q. -- you were trying to answer you described at the beginning?
A. I guess two questions, whether -- whether this device led to an increased risk of SSIs or whether it was defective.
Q. And you told us earlier that you believed, based on your history, that it was a safe device.
A. Yes.
Q. Okay. Let -- let's talk about a little farther down on page three. There's another statement, doctor, on page three where you state that the factors that are --

Well bear with me because I think it's a typo. In the middle of the second paragraph -- do you have that in front of you, the paragraph that starts "A brief discussion...?"

A. I'm looking at it, yes.

Q. Okay. It says, "The factors that are can cause..." I think -- I think maybe there's a superfluous "are" there. I think it means, "The factors that can cause PJIs involve the host and the environment." Would you agree with me that's the way that should read?

Well let's forget about it. I'm not worried about the "are." Let's -- let's read it as it is. "The factors that are can cause PJIs involve the host and the environment."

The fact is, however you read the "are" and the "can," that's a bit of a misstatement; isn't it, doctor?

A. I -- I don't know. What are you --

Q. Well --

A. Well if I said "are" and "can," that's a misstatement. It's obviously --

Q. Well --

A. Thank you for pointing that out. There's -- there's --



Q. I'm not worried about that, that's why I tried to correct it. I'm not worried about it. My -- my real question is, doctor, even with a correct of that -- correction of that typo, the statement that PJIs are caused by the host and the environment is inaccurate; isn't it?

A. I -- I think in some ways you can say it's semantics. You --

Q. Well a microbe can cause --

A. I -- I might say it better that --

THE REPORTER: I'm sorry.

MR. B. GORDON: Sorry. Go ahead. Go ahead, doctor.

A. Do you want --

Q. Let me start it -- I'll re -- I'll start the question over.

Doctor, you have to have a microbe of some kind to cause an infection; don't you?

A. Yes.

Q. Okay. So like the old adage when we were kids and -- and maybe our moms or parents told us don't go outside without your coat on or without your shoes on, you'll catch cold, that's just -- scientifically that's just nonsense; right?

A. Don't go out --



MR. C. GORDON: Object to the form of the question.

A. Not necessarily anyway, but keep going.

Q. Well doctor, you can't catch cold --

THE REPORTER: Off the record.

(Discussion off the record.)

BY MR. B. GORDON:

Q. All right, doctor, let's start again. So let me ask you a question. You can't catch a cold, a rhinovirus, without being exposed to someone else with an infective organism; correct?

MR. C. GORDON: No.

A. That's not correct.

Q. Okay. So -- so it's your testimony that you can catch a virus without being exposed to the virus? How does that work?

A. I didn't say that.

Q. All right. Well I'll ask you another question. Let me ask it this way: Can you go outside and catch a virus simply because you're not dressed for inclement weather? Is that possible?

MR. C. GORDON: Object to the form of the question.

A. I don't know how to answer the question. If somebody has their --



If they're not dressed appropriately and their immune system is down, they may be more susceptible to ambient rhinoviruses or parvoviruses in the environment from droplets that they could theoretically be at increased risk, and there are anecdotal studies like that that I've seen, but I'm not -- where they say, "Maybe what mom said was correct," but I'm not an absolute expert on that topic, so I think we should use perhaps a different analogy. I understand that you're saying that about cause and effect.

Q. Thank you for that clarification, doctor. And I -- I guess that that's really my point, is that those airborne droplets you mentioned of microorganisms, viral or otherwise, whether you have a susceptibility or not, you at least have to have them in order to come down with the virus; don't you?

MR. C. GORDON: Object to the form of the question.

A. The question is --

I think you're saying that to get an infection you have to have the antecedent infective particle, DNA, virus, bacteria, and the answer to that question, if that's what you're asking me, is yes.

Q. Thank you, doctor.

Let's move on in your report a little farther down. In the same paragraph on page three you state, quote, "Host factors" -- make sure I get this right. "These host factors can have an enormous impact on the patient's own bacterial burden, as well as the patient's ability to resist infection from endogenous bacteria (bacteria that come from the patient)."

Do you see where I'm reading?

A. Yes.

MR. C. GORDON: You read it wrong.

MR. B. GORDON: Okay. I'm sorry. Let me read it again.

Q. "These factors can have an enormous impact on the patient's own bacterial bioburden, as well as the patient's ability to resist infection from endogenous bacteria (bacteria that come from the patient)."

MR. C. GORDON: Now you got it wrong in a different way, but --

A. You left out the word -- the second word "host" this time. But other than leaving out the word "host" when you read this this time --

Q. "These host factors..." All right. I apologize.



A. -- then that's the sentence, yes.

Q. Well my question --

I wanted to alert you to that sentence, and my question about that is: What do you mean by "bacterial bioburden?"

A. Again, I wrote this now --

I did read this a few times over again. I was using this material just as a little bit of a background, so I don't know exactly what I meant. But when I'm talking about bacterial bioburden, we're talking about the amount of bacteria on the patient's skin, sometimes in their nasal -- their nares and their whole body, sometimes even in their GI tract, sometimes --

For example, it would be considered an excess bioburden if somebody had an open sore on the same leg that we're doing a knee replacement. That might increase the bi -- the bacterial bioburden. I think this -- these were general comments that I made about patient-specific bacterial bioburden.

Q. So let me ask you, with respect to a patient's own bacterial bioburden: Their bacterial bioburden in and of itself, regardless of what level that may be at, cannot cause their infection; can it, doctor?



A. I -- I --

MR. C. GORDON: Object to the form of the question.

A. I don't see why not.

Q. Well let --

A. What -- what are you --

Unless I'm missing something of what you're asking me here.

Q. Yeah. Let me ask a followup question. The bacteria that you're referring to, whether there are few or there are many, the bacteria have to find a route, a mode of transmission to the patient's immune system or to their body internally to cause an infection; don't they?

A. I guess I would agree with that, yes.

Q. Okay. So, for example, I think you mentioned --

Well I don't want to talk about science day.

So there are advantageous -- to use a word -- bacteria on our skin; are there not?

A. Yes.

Q. And there's evidence that there are certain symbiotic relationships between bacteria both on our skin and inside of us that are written about; is that fair?



A. Yes.

Q. And so just because someone has a particular type of bacterium on his or her skin doesn't mean they're going to get an infection; does it?

A. Correct.

Q. Okay. On the bottom of page three you talk about a --

A. Ahh.

Q. Sorry.

A. Excuse me. I'm going to amend that last answer. Sorry. I answered a little too quickly.

It is potentially possible that a person that has a particular type of bacteria -- I have to think about this answer -- that is pathologic as opposed to a more friendly bacteria, that if they have that particular bacteria on their skin, that could lead to an infection because it's not --

I think that's a better answer. And for the most cases my answer was correct, but there can be a scenario where you have a, quote, bad bacteria that is not good.

MR. B. GORDON: Objection, move to strike as non-responsive everything after the word "yes."

Q. Doctor, at the bottom of page three you talk about exogenous sources of bacteria. Do you see that?

Just before the bottom. You state, "These host factors can also diminish the ability of the patient to void infection from exogenous sources of bacteria (external to the patient) as well." Do you see that?
A. I see the sentence.
Q. I'd like to know if you have any specific citations of authority for that sentence.
A. I have to read the sentence more than once because it's a little bit --
I have to remember what I was thinking when I wrote this.
Q. And just for the record, while you're reading, doctor, I'm not asking you necessarily what you were thinking or what you're thinking about it right now in terms of what it means, I'm just asking you if there's anything on your Exhibit A references and materials considered or any citation you can give us right now that specifically supports that proposition.
A. I'm looking here --
I would have to go through this whole list to see what supports that. I think Parvizi, "Prevention of Periprosthetic Joint Infection," so it's under Parvizi -- P-a-r-v-i-z-i -- would support that statement.



Q. And Dr. Parvizi is a doctor here at the Cleveland Clinic; isn't he?
A. No, he is not.
Q. He's not -- he's not here? Was he at one time?
A. Never.
Q. Okay. Where is he located?
A. To the best of my knowl -- to the best of my knowledge, never.
Q. So where is Dr. Parvizi?
A. He is at The Rothman Institute in Philadelphia, Pennsylvania.
Q. And is he --
A. That's R-o-t-h-m-a-n.
Q. Is he part of 3M's infection prevention team, to your knowledge?
A. I don't know. He might be.
Q. Okay. Let me ask --
A. I --
Q. Sorry. Go ahead.
A. Can I qualify this? I don't really know what 3M -- what you just asked me in answer to the question. I didn't know that -- if there is a 3M --
Q. Infection prevention --
A. -- whatever you said, infection prevention



team. I wouldn't know what that is.
Q. Well what about Dr. Sessler? You know who Dan Sessler is; right?
A. I know who Daniel Sessler is, if it's the same Dr. Sessler you're talking about in this -- that's related to this.
Q. And he's at the Cleveland Clinic; right?
A. He is.
Q. You're not aware that he is part of the infection prevention team at 3M?
A. I'm not. I didn't even know 3M had an infection prevention team. It's not part of my review.
Q. So following up on your report, from page three and page four you talk about sources of what you call, again, exogenous bacteria. For the benefit of the jury, how would you define "exogenous sources of bacteria?"
A. Exogenous can come from any -- anything from, I guess simply -- I don't want to confine my answer but -- outside the patient. Like from, if we're talking about in the OR, the different -- me as a surgeon, if I shed some bacteria, some skin squames or fomites or things are -- anything outside the patient would --



Obviously, the word "exogenous" means outside.
Q. So anything in the operating room that might contribute to an infection other than the patient him or herself; is that fair?
A. That might be fair. Let me think about it, if that's the only context here.
Yeah, I -- I would -- I would say that's fair.
Q. And you say at the top of page four that "The operating room environment has a multitude of sources of potential contamination;" correct?
A. Yes.
Q. And you mention a number of them, such as minimizing operating room traffic; right?
A. Yes.
Q. And contam -- decontamination --
Or be -- I'm sorry -- being careful about contamination of necessary equipment, and you list several things there; right?
A. Yes.
Q. So the point of this section is that you do everything in your power and surgeons do everything in their power to minimize the risk of these exogenous sources of contamination; right?

A. What we can, yes.
Q. And you mention a number of things here and then later in your report. I notice one thing you don't mention are heat -- heater-cooler devices. You're familiar with those; right?
A. I'm familiar with heater-cooler devices.
Q. They're used in cardiac surgery; right?
A. Well I'm not a cardiac surgeon, but I know that they do use these water devices. Sometimes they use different types of devices. But I'm not a cardiac -- cardiothoracic surgeon. Last time I was there was as a resident, which is a few years ago.
Q. But you are aware that they are used in some hospitals in some surgeries to both heat and cool patients; correct?
A. Say what these devices that you're re -- this class of devices you're talking about.
Q. Heater-cooler devices. They are used both for heating and cooling of patients; aren't they?
A. Yes. But not -- I don't --
I'm not an expert on that. I've seen that written. I haven't seen those devices personally with my eyes lately. I will accept it, I've read about it, but I don't --
They're not used in orthopedics. I don't



know the -- the details. I'm happy to -- to answer your question by looking it up or going to the cardiothoracic room and get better knowledge.
There are -- I'll add that there are some other heating devices when we heat up -- that we use in orthopedics just to heat up fluids when we have the, you know, cool fluids that come out of the freezer that we need in the OR, that gets in the OR to heat up --
Q. Doctor, are you aware -- sorry.
You're aware, are you not, that heater-cooler devices have been found to be sources of contamination in operating rooms? You're aware of that; aren't you?
MR. C. GORDON: Object to the form of the question.
A. I think I've heard about that. And I don't want to answer imprecisely, but certain -- certain may have been.
Q. So doctor, if there are multiple studies over the course of the last two years and FDA and CCD guidelines with respect to contaminated heater-cooler units causing bacterial infections of cardiac patients, are you telling this jury that you just don't know about that?



MR. C. GORDON: Object to the form of the question.
A. I know about that to an ex -- to a very minor extent, because to me they are -- those are different devices. There are -- there's certainly a lot of different devices in multiple specialties, and I'm trying to confine this to what is used in the -- in -- for this device.
Q. Well when you say "for this device," do you mean the Bair Hugger?
A. Or the --
We can take it as the Bair Hummer -- Bair Hugger or devices that are -- that are designed to promote normothermia.
Q. So other types of patient warming systems.
A. Yeah.
Q. But in your report, doctor, on page four and later, you mention a number of different devices that are potential sources of exogenous contamination based on your expertise and based on the literature; right?
MR. C. GORDON: Object to the form of the question, it's argumentative, assumes facts not in evidence.
He -- he's listing orthopedic devices.
MR. B. GORDON: That's a -- that's a good



speaking objection. You got onto me about it.
Q. So doctor, I'm going to repeat the question. I don't think it's argumentative.
A. Okay.
Q. The question is whether, in your report, you listed a number of different operating room devices that you believe are things that have to be looked at with respect to potential contamination of the operating room environment. Isn't that what you said on page four?
A. It -- I used a --
Yeah. You're using the term "devices." Some of these things are -- I don't know what the definition that you have of "devices" -- some of them are blades, --
Q. Well doctor, you said --
A. -- tips -- suction tips. I mean they can all be considered devices. Some of them are operating room traffic. I just -- I just listed a melange of things in the orthopedic theater that are used that are exogenous sources of -- potential exogenous sources of contamination in the operating room theater and --
But I'm happy to answer any question you're asking.

Q. Let me read your -- let me read your sentence exactly, doctor, so it's clear for the jury. And I want you to listen for me here and ask you where you limit this to orthopedic cases.

Top of page four, quote, "The operating room environment has a multitude of sources of potential contamination. This should be minimized, as much as possible, by not prolonging surgeries unnecessarily to minimize further skin or wound contamination, minimizing operating room traffic, and being careful about contamination of necessary equipment, e.g. suction tips, blades, saws, light handles, et cetera."

Anywhere in those two sentences did you limit your concern about the operating room and potential contamination to just orthopedic cases?

MR. C. GORDON: Object to the form of the question, --

A. I -- I --

MR. C. GORDON: -- it mischaracterizes -- wait, wait, wait -- mischaracterizes the -- the -- the evidence, takes it out of context. And the entire section is about periprosthetic joint infections.

MR. B. GORDON: Object to counsel's side-bar and testifying for the witness.

A. I -- I would have answered it without his



prompting in two manners. I would have said that the -- what we said, the bold part of this topic is periprosthetic joint infections, so what I'm saying in here primarily applies to -- to joint arthroplasty surgeries, which is the major topic of this whole case, which is what we're talking about. That would have been my first answer. But the second part is when you were reading it carefully to me, I was listening and reading it again carefully. Would I agree with almost all of those statements being correct in a generic sense for the operating room? I didn't write it in that -- I -- I was writing this more for orthopedics and for joint arthro -- arthroplasty when I wrote that. I know how I was thinking because I was just imagining myself doing a joint arthroplasty case, and that's how I wrote it. I didn't write this from a book.

You're asking for references sometimes. Some of these -- some of these statements here in this -- even in this whole section, they're not referenced because it's from my knowledge. I believe a lot of it is common knowledge like what I put in there. But if I read that, unless we nitpick this on something else, I think that statement also applies in general to any surgery.



Q. Doctor, you would agree -- and I think you did earlier -- with the proposition that patient warming devices are potential external sources of contamination in the operating room; --

MR. C. GORDON: Object to the form --

Q. -- correct?

MR. C. GORDON: Object to the form of the question.

Q. In orthopedic cases.

A. No, I don't agree with that.

Q. So you don't agree that patient warming devices are among the pieces of equipment in the operating room, like this litany of others you list, that could be sources of contamination in orthopedic surgery cases?

A. Well you want to go one by one? What are we defining as patient warming devices? If you bring -- if you bring a little hot -- if you bring a little IV fluid that's a little warm and you call that a patient warming device -- which it shouldn't be, it shouldn't be used for that purpose -- and the thing is contaminated, it could cause bacteria. Is that what --

I mean I don't understand what the question is.



Q. Doctor --

A. Which one are you -- which, quote, patient warming device are we referring to and what are you --

Some things heat patients up in the OR. There are different devices.

Q. So doctor, is it your testimony to the jury that some patient warming devices that might be used in cardi -- I'm sorry -- orthopedic surgery may pose a risk of contamination but others do not?

A. I don't think that's my opinion.

Q. Isn't that what you just said?

A. No, that's not what I just said.

Q. So is it your testimony that --

A. What you're saying is -- it's out of context.

Q. So is it your testimony that no patient warming devices can be external sources of contamination, as you've described them in page four of your report?

MR. C. GORDON: Object to the form of the question.

Q. I just want to be clear. Is it none or is it some?

A. I have to go and think about every patient warming device that's been used and on the market. I

would go through a review of the --
There are a number of review articles on different patient warming devices. I don't want to answer incorrectly here. There are ones that go through a whole litany of different types of patient warming devices.
Q. Well doctor, you had --
A. And then I would basically go through that article and go one by one and say do I think that any one of these could potentially pose a risk of increasing bacterial contamination. On the --
In the general sense, my answer is no.
Q. Doctor, you had a lot of days before today to consider whether forced-air warming or other patient warming devices, such as all these other sources of heat and other equipment in the operating room, whether any of these things contribute to or cause infection; didn't you?
A. Yes.
Q. You -- you had hours and hours that you billed Mr. Gordon for, including up through just the last couple of weeks, for reviewing the literature and studying the very question that -- that I just asked you, whether any sources of contamination could be forced-air warming devices. So you've considered that



question already as you've written your report here; haven't you?
MR. C. GORDON: Object to the form of the question.
A. I don't know what the question -- you -- it keeps -- the --
The phrases of your question keep changing if we read the last three statements -- or no, your statements keep changing. But yeah, I think the answer is: I've considered different -- I've -- I've considered forced-air warming devices and did a lot of work on this case to look at risk factors.
Q. And your opinion is that forced-air warming devices do not cause or contribute to orthopedic -- periprosthetic joint infections; right?
MR. C. GORDON: Object to the form of the question.
A. I didn't look at every forced-air warming device ever in the history of mankind, if that's what you're asking.
Q. How many --
A. I only really looked at the Bair Hugger device. There's a number of others on the market, and I -- I didn't -- you don't --
I didn't do a major assessment of these



other devices, if that's what you're asking.
Q. One of the other ones on the market is the Mistral, marketed in this country by Stryker Corporation. You're familiar with that one; right?
A. Yes.
Q. In fact, that's the one you use at the Cleveland Clinic; right?
A. Yes.
Q. You don't think that one causes infections; do you?
A. I don't think it causes infections at the pre --
I'm a little concerned because there was an increased -- in comparison to the Bair Hugger, in the recent report that we have there was an increased -- although not statistically -- there was an increased rate of deep infections when we did a comparison of the Mistral to the Bair Hugger device, so I think that may prompt a further investigation. Because if that type of numbers keep adding up, then I'd like to know why that occurred.
There may be many other factors so I would never want to imply that, but if anything, there was an increased rate using that device. But that's -- but --



So let's see. The overall answer, you're asking do I imply that.
Q. I'm happy to ask you another question, doctor. I think --
A. I'm -- I'm looking into it, --
Q. Okay.
A. -- but I don't see any difference -- statistical difference between those. And I would say no, they do not increase risk of infection.
Q. Based on your answer, then, I would take it, for the jury who is going to hear this, that you still have an open mind as to whether some forms of forced-air warming may actually contribute to contamination of the surgical site.
MR. C. GORDON: Objection --
A. I have an open mind always to anything -- a lot of things that you may ask me, as you see that I do a lot of research projects, so I'm always looking for signals or ways to -- to help patients increase their safety, be aware of any trends or things --
Q. So as we sit --
A. -- that cause --
Q. Sorry.
A. -- that cause problems with patients. I have an open mind with all these things. As we sit

here today, I don't think that there is a problem with -- with those two forced-air warming devices. I don't have tremendous knowledge of any of the other forced -- forced-air warming devices, so -- which is part of your previous questions that I couldn't answer exactly.

Q. So as we sit here today, you have not ruled out the Mistral or other forms of forced-air warming that you haven't evaluated being a potential contributor to contamination of the surgical site.

MR. C. GORDON: Object to the form of the question.

Q. You haven't looked at those. You haven't ruled them out.

A. Wasn't part of what I was being asked to do.

Q. So the answer is you have not ruled those out; is that fair?

A. Yes.

Q. Okay. When did the Cleveland Clinic switch to the Mistral from the Bair Hugger?

A. I can look at this abstract, and I think the exact date --

There's an abstract as one of the exhibits, it's Exhibit 11. This represents a study comparing the --



Q. And -- and doctor, just -- not to interrupt you, let me catch up with what you're saying. I'm -- we're going to ask you about that, but my question right now is just do you know when the Cleveland Clinic switched to that device?

A. I can't --

I'd like to give you an exact date --

Q. I don't need an exact date. Approximately. Couple of years ago?

A. I think around 2014 --

Q. Okay. And --

A. -- but I don't --

I apologize.

Q. Do you know --

A. I think it's about 2014. I don't know if that's an exact answer, whether it was my orthopedic department that switched or the Cleveland Clinic, because you asked me about Cleveland Clinic, so the better answer would be around 2014 for joint arthroplasties is when the switch was made.

Q. And that's all I'm looking for is your best recollection, doctor.

A. Okay.

Q. That's fine.

Do you know why they switched?



A. The best of my knowledge, when I asked this, it was a cost issue.

Q. Okay. Can you give me any details about that?

A. I think that it was just a matter -- what -- what we do at --

We have a supply chain department that looks at different devices. When they see -- they get different bids every few years for different products, and if they see equivalent devices, they get -- they -- what they presume are equivalent devices -- that's just an example -- they would look at -- they would try to get the best bid. Cleveland Clinic is a large provider, and when you get competitive bids at reduced prices, they save a lot of money.

Q. Who told you that?

A. So --

Who told me? That's what I -- that's part of my role here, is to be looking at supply chain things for the whole department.

Q. I'm sorry, let me narrow my question, doctor. My question is if you knew why they switched and you indicated it was a cost issue. Who told you that? That's what I'm asking.

A. I don't remember who -- I --



I brought it up when I got here at a -- one of the joint arthroplasty clinics. To the best of my knowledge it -- one of the orthopedic surgeons --

There is a supply chain committee that makes these decisions for the whole institution. I can't tell you exactly how many people are on the supply chain committee. It's about 15 or 20 would be a guess. But that group, two of them are orthopedists --

Q. Who are they?

A. I don't know if I should be telling you names of people that are not involved, so I'll -- I'll -- I'll ask --

Q. Doctor --

A. -- I'll ask my lawyers. I don't want to --

Two of them are orthopedists, one of them is -- in particular is a joint arthroplasty surgeon, --

Q. Well I'm going to need their names.

A. -- one of them is a pediatric surgeon --

Q. There's nothing privileged about their names, doctor. I'm going to need their names.

A. I'm going to continue with my answer, please.

Q. No. So you're refusing --

A. Can -- can I -- can I continue with my answer without being interrupted? You asked me a question. I'm trying to answer the question.
Q. The question is: Who are the doctors?
A. Okay. I haven't finished my answer and you keep --
You've interrupted this answer about five times. Five. Would you --
Q. Do you want him to read back the question?
A. I don't need to be --
I'm in the middle of answering the question you asked four --
Let's -- let's take a time out.
Q. Doctor --
A. Let's take a time out. We're not going to continue where you ask me a question, in the middle of my answer you've interrupted me five times.
Q. Doctor, if you need a break --
A. In fact, I'm giving this fellow a break because he made the comment as well as me.
Q. I'm trying not speak when you speak, doctor, for his sake.
A. We're taking a timeout.
Q. But for the record, --
A. We're taking a timeout.



Q. -- I'm objecting to the break. We're still on the record and I'm objecting to the doctor walking out of the deposition.
MR. C. GORDON: And we're on --
We're taking a break.
THE REPORTER: Off the record, please.
(Recess taken.)
BY MR. B. GORDON:
Q. Did you have a good break, doctor?
A. Yes.
Q. Let's back up for a second, maybe make this a little simpler.
And one thing I probably forgot, I don't know what we said what the Mistral is. Could you tell the jury what the Mistral is?
A. I don't know everything about the Mistral, but it's a forced-air warming device that has a HEPA-type filter, would be one of the features. I'm trying to think of some of their -- of the other features. There's one I can't remember right now. I could look at the abstract. But I'm happy to --
I didn't focus a lot of this on that device.
Q. Well for the jury that may read this, one thing is they're quieter than the Bair Hugger; aren't they?



A. I don't know that.
Q. Okay. Do you know whether they cause lofting of the blanket up off of the patient like the Bair Hugger?
MR. C. GORDON: Object to the form of the question.
A. I can't give you an answer to that.
Q. Well you use them; right?
A. Well I haven't noticed --
Q. Lofting?
A. -- lofting that bothers me with the Bair Hugger or the Mistral.
Q. Well --
A. There hasn't --
I don't know what you -- how you term "lofting." I don't notice it, that it -- it to me affects my surgery or --
Q. To be fair, doctor --
A. -- insurance.
Q. Sorry.
To be fair, doctor, you know that the Bair Hugger blankets are well known to loft up off of the patient unless you put extra blankets on top of them; right?
MR. C. GORDON: Object to the form of the



question.
Q. You know that.
A. That doesn't typically --
It hasn't been something I'm concerned about.
Q. Well, not concerned about it, but it happens; right?
MR. C. GORDON: Object to the form of the question.
Q. Is it your testimony under oath that Bair Hugger blankets do not loft up off of the blanket -- off of the patient unless you put extra blankets on top of them? Is that your testimony?
MR. C. GORDON: Object to the form of the question.
A. I don't have -- I don't have an answer to that one way or the other.
Q. Well do other orthopedic surgeons talk about that?
A. No.
Q. Okay. So if another orthopedic surgeon comes into trial and testifies if that happens, he's lying, he's mistaken?
A. Excuse my answer to -- when I said "no." To the best of my knowledge it's not a part of our --

I can't say no. Other orthopedists may talk about what you're talking about, but I haven't witnessed the thousands and thousands of orthopedic surgeons that I encounter talking about that.

Q. You mentioned that the Mistral has a HEPA filter whereas the Bair Hugger does not; correct?

A. Correct.

Q. And that's a higher level of filtration, the HEPA filter, than the MERV 14 filter or the M20 filter, or however you want to describe it, that is in the Bair Hugger; isn't that right?

A. I don't know how you're defining "higher level." You -- you're defining it filters a certain amount -- it --

It does have a higher filtration efficiency for certain size particles, if that's how you are defining "higher level."

Q. Are you an expert on filtration efficiency, doctor?

A. No, I'm not an expert on filtration efficiency.

Q. You're not an engineer; right?

A. I am not an engineer.

Q. Have you ever designed a patient warming system of any kind?



A. No, I have not.

Q. And you would then defer to others in terms of the differences in filtration efficiencies between different patient warming devices I assume?

MR. C. GORDON: Object to the form of the question.

A. Not necessarily.

Q. So you would not defer to experts in those areas on the questions of filtration efficiency level?

MR. C. GORDON: Object to the form of the question, lack of foundation.

A. I think there are others, and even in this -- in this trial, who are more expert than me, but that doesn't mean I'm always going to defer to others. If you were pitting me right now against many other orthopedists, because of the nature of this case I might know a little bit more about the filtration than a standard orthopedist, but --

So I don't know what you're asking. If you want me, I can say that, yes, there are experts in this case that will talk about the filtration -- filter that I would defer to --

Q. And you --

A. -- on those issues.

Q. Thank you.



And you brought up the fact that the Mistral has a HEPA filter unlike the Bair Hugger; correct?

A. Yes.

Q. And are you aware that HEPA filters cost more than non-HEPA filters, doctor?

A. I would imagine they do, because --

I don't know exactly what the costs are, but I imagine -- hmm.

Obviously, laminar flow has HEPA filters. I'm trying to think where I would know -- know that.

So the question is do --

Q. HEPA filters --

A. -- HEPA filters cost more than what filters?

Q. Non -- non-HEPA filters.

A. It would --

You would have to tell me what was the non-HEPA filter. I mean I -- I don't know the real -- I never looked at costs of things like this. There prob -- there might be --

Like what is there, the other filters? There's an ultrafilter. What is that?

Q. Doctor, would --

A. If there's an ultrafilter, that might be more expens -- would be considered a non-HEPA filter that in the category of your question might be more



expensive than a HEPA filter. So I don't -- I --

The reason I brought it up is because a number of articles that I have seen -- and I'm volunteering something now -- mention the need for a HEPA filter on the device used here, on a forced-air warming device, and yet here is a forced-air warming device that has a HEPA filter and had no difference in infection rates. That's --

(Witness's cellphone rings.)

Q. And we'll talk about that in a moment.

A. I'm volunteering that.

THE WITNESS: I won't answer.

MR. B. GORDON: Do you need to take a break, doctor?

THE WITNESS: No.

Q. Okay. And we'll talk about that in a moment. But that's at least one difference between the Mistral and the Bair Hugger that you mentioned. The Mistral has a HEPA filter, the Bair Hugger does not; correct?

A. Correct.

Q. And would it surprise you if an expert came into court and testified that a HEPA filter costs more to manufacture than a non-HEPA filter? Would that surprise you?

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A. It wouldn't surprise me.
Q. And yet it's your testimony that the reason that the Cleveland Clinic switched to use of the Mistral system from the Bair Hugger was strictly a cost-savings issue. Isn't that what you told us?
MR. C. GORDON: Object to the form of the question.
A. Yes, but the cost might not be only the filter, --
Q. Well --
A. -- might be other reasons.
Q. And that's why I wanted to find out more information. And now that you had a break and talked to counsel, can you give us the names of -- let me finish, please -- can you give me the names of anyone, orthopedic surgeons or otherwise, who may have been involved, to your knowledge, on the decision to take out the Bair Hugger and replace it with the Mistral at the Cleveland Clinic?
A. So I don't know if they were involved because they're on the supply chain now; they may not have been on it. Two were Robert Molloy --
Q. Molloy?
A. Molloy, M-o-l-l-o-y, Robert, and David Gurd.
Q. How do you spell that one?

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A. G-u-r-d, David.
Q. And they're both orthopedic surgeons at the Cleveland Clinic?
A. Yes.
Q. Anyone else you can think of as we sit here?
A. No, I don't know who else is on that supply chain. And they -- in addition, they may not have been involved when that decision was being made.
Q. Do you know -- and I'll follow up on that last answer -- do you know, then, who made the final decision?
A. If you want as my answers to you, trying to be as responsive to you as possible, these are the type of things I can try to find out if you would like.
Q. I appreciate that. I -- I would -- I would follow up and ask you, doctor, if you would let counsel know, to provide us with the names of anyone that you believe may have been involved in the decision to switch from the Bair Hugger to the Mistral, we'd be grateful for that. Thank you. You'll do that for us?
A. I'm writing it down, yes.
Q. Thank you, sir.
All right. Let's talk about that abstract

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that you mentioned. I think it was Exhibit E to your expert report, and I think he's marked it as --
MR. B. GORDON: Sorry, do you want to say --
MR. C. GORDON: Eleven.
MR. B. GORDON: Okay, thank you.
Q. -- Exhibit 11. You have that in front of you; right, doctor?
A. Yes.
Q. So first of all, this was not --
Well let me ask you first: You were not involved in any way in this study; is that fair?
A. I was not involved with this study.
Q. And this was not a random controlled trial -- a randomized controlled trial; was it, doctor?
A. No, it was not.
Q. So was there any --
I mean do you know what they did with respect to issues like -- on the patients involved concerning things like the type of skin prep that was used, whether it was chlorhexidine as you mentioned or something else?
A. Can you ask me the question better? I -- I don't want to --
Q. Sure.

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A. -- give you an answer that I'm giving you that may not be the answer --
Q. Absolutely.
A. -- you want to hear about. I don't know exactly what you're asking.
Q. I'll be happy -- any time you want, I'll try to rephrase things.
Let me ask you first: Do you know who funded the study?
A. To the best of my knowledge, 3M funded this study.
Q. Okay. Thank you for that. Do you know what -- well I --
Let me ask you: This was a retrospective study; right?
A. We have a database that we keep of -- of all the joint replacements that are done. The database goes back like over 10 years. Some information is more robust than others; keeps getting better and better. The -- our -- our database the last -- for example, last year's is -- last year or two is even superior, like '16 and '17, because we have a new database that -- that patients get entered right away. But we have not only --
I don't know exactly how they did this, but

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we had databases there with great information. That's part of the pride of what Cleveland Clinic does with their studies. That's why they're --

But in addition, there are a lot of research fellows; namely, I believe, right now as we're sitting here there are eight research fellows that are just in the joint arthroplasty division. So -- so if you look at this paper, there were two -- the first two authors are research fellows, so to some extent they were able to look at the existing databases. Again, I don't know this, but I imagine, since I'm involved every week in the studies, that's pretty much probably how it was done, they looked at the databases. But I could be --

Another thing that I -- to finish this answer, Cleveland Clinic keeps a lot of records on -- on SSIs, wound infections and deep infections as part of quality control, so some of this data could have been gathered from knowing -- from the quality control records as well. So there's a combination of different sources for not only getting the data but also confirming that the data was accurate.

MR. B. GORDON: All right. Objection, move to strike, non-responsive.

Q. And doctor, I'm not meaning any disrespect,

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but I want to be clear this time. I didn't say a word in -- during that five-and-a-half-minute answer out of respect for Mr. Stirewalt now, how hard he's working here and how bad the record's going to be if we don't all comply. So my question -- and he can read it back if you don't believe me -- was simply: This was a retrospective study; wasn't it, doctor? Now I'm just asking --

A. But --

Q. Let me finish. Let me finish.

And I'm just asking you to work with me. I understand your whole answer was intended to give me all this information about how robust the Mayo -- I'm sorry, another robust clinic out there -- the Cleveland Clinic is and all, and that's all well and good, but if you give me a five-minute answer to every question that I'm just asking for is it a retrospective study or not, we'll never get done here, doctor. Do you understand that?

A. I apologize to you.

Q. Thank you. I appreciate that.

So is it yes, it's a retrospective study?

A. Yes.

Q. And -- and that's okay; right? I mean it has its value; right?

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A. Yes.

Q. Just the fact that it's not a random controlled -- randomized controlled trial doesn't mean it's worthless; does it?

A. Correct.

Q. Okay. Thank you.

Do you know if the differences in this study were stratified by or -- or analyzed by total hip arthroplasty versus total knee arthroplasty? Did they say that?

A. I'd have to look. Since I wasn't involved in this study, I don't know all the details of the study, so I -- I'd have to look right now.

Q. All right.

A. Pretty much all the study that I know about is on this page.

Q. Yeah. It's a one-page abstract and an attachment with three tables on it; right?

A. Right. So if you want me to answer that question, I'd have to look at this a little more carefully now.

Q. Sure. And -- and --

A. That's all the knowledge I'm going to know.

Q. Sure. And while you look at it, I'm going to ask one more question, but then go ahead and look

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at it.

The full paper is coming out in like a week or so; isn't that right?

A. Well the presentation will be at the MSIS meeting, and I can't tell you when the full paper will come out. It -- it's not going to be a week or so, it will probably --

Q. I thought there was an indication in looking in your -- in your report or somewhere that it was coming out on August 5th.

A. The presentation is August 5th. If I said the paper is, then I was mistaken.

Q. And that's MSIS. Where is that?

A. I don't know where it is this year. I'm not going.

Q. What does that stand for for the jury?

A. Musculoskeletal --

Q. Something Society?

A. -- In -- Infect --

It might be Musculoskeletal Infection Society. If you want, in the break I can look that up and I'll give that to the court reporter.

Q. That's all right. But you're not going to it.

A. And I can tell you -- I'll be able to tell

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you the exact dates and where it's located because I didn't have those answers for you, but I can get those easily enough.
Q. And when you say "the presentation," you mean there won't be any more written documentation presented in this, or do you know?
A. Not all meetings but this meeting in particular is presented and then it's -- and then the presentation, I would assume, would be some time like --
Well, I don't want to go crazy on this answer. You're asking me can I go and tell you the sequence here about how this will go towards presentation?
Q. Actually, let me withdraw and ask another question because it reminded me while you were talking.
What leads you to believe that 3M funded this study? How do you know that?
A. I don't know whether I got that information from the legal team or I got that from Carlos.
Q. Who is Carlos?
A. Oh, I'm sorry.
Q. One of the authors?
A. Carlos Higuera is the senior author here.

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Q. So if I wanted --
A. In fact, no, I know that, that he applied for funding and they give him some funding. And why do I know that? Because I have to sign off on all these studies --
Q. All right.
A. -- and proposals, --
Q. As the chairman?
A. -- so they -- so they --
Yes.
Q. Okay. Fair enough.
A. So they would have been --
That would have come.
Q. Fair enough.
One question I had about this, and I realize it's limited information and if you can't tell it from the paper, that's okay, but I notice they had data on one set of patients from 2013 and one from 2015, which I think, you know, is the non-Bair Hugger group or the -- what they call the FAW-HEPA group, presumably that would be the Mistral group, and that's because they had to wait until after they switched to the Mistral to have those data, I assume; right?
A. Well you -- I --
MR. B. GORDON: Do you have our copy of

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this?
A. I don't know what you're asking me exactly, but you do want to wait a year to see the -- is there an infection. If you're looking at infections, you don't -- you do the procedure and then you wait to see how many infections occur in that year to see an infection rate.
Q. So is your testimony they should look out to a year to see how many people --
A. Not necess --
Q. -- are infected?
A. I don't know what they did, if they looked at 30-day infection rates or 90-day. It used to be a year by the --
Q. CDC.
A. -- by the CDC, but I think they've changed some of their criteria to 90 days now. I don't want to say that with a mistake.
Q. And if they only look to 90 days here, wouldn't that be a concern to you as an orthopedic surgeon knowing that sometimes patients don't get followed up on and don't report infection complications until after 90 days?
A. It wouldn't be a concern about the study if they were consistent, they looked at 90 days in the

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2013 group and 90 days at the 2015, as long as they're reasonably consistent in what they're looking at, --
Q. Well --
A. -- if that's what you're asking. I -- I don't know if that's what you're asking me.
Q. Not exactly. Let me ask it this way: If they only looked at patients out to 90 days, isn't it possible and in fact in your vast experience as an orthopedist isn't it likely that people -- patients after 90 days may have developed and been diagnosed with periprosthetic joint infections after 90 days but in less than one year that -- that aren't going to be found in this?
A. It's likely that that will occur, but a lot of periprosthetic ones -- and that's why the CDC, I believe, changed their stance to 90 days, because the majority -- and I can't tell you whether that's an 80 percent majority -- are typically found within the 90-day period.
Q. Can you --
A. There are -- there are certainly --
The answer to your question, yes, it's likely that there will be cases that occur between 90 and a year that would have been undetected before the 90 days. I think that's what you're asking me.

Q. Yes, sir. Thank you.
So the 2013 was the set of patients who were before the Cleveland Clinic switched to the Mistral, that was the Bair Hugger group or the -- what they call the non-HEPA group or -- or the CFAW group I think they refer to it as, the 2015 cohort are the patients who received treatment using what they call the FAW-HEPA or the Mistral that Cleveland Clinic is using now.
What about 2014, why didn't they include any patients from 2014?
A. Okay. First of all, anything you're asking me, I mostly would have to read this very carefully because, number one, it hasn't been presented, I don't know all the details, and a lot of the details of what I know is exactly what you know. We can read this together if you want me to give you an answer, and I can --
Now I can help you because I read abstracts all the time, so if you can -- I could try to read this and try to help you with an answer and say why didn't they do the 2014. I gave you a guess before about when this switched and I guessed right, I believe, 2014, but I don't know when in 2014, so it --
A potential answer to what you just asked me



could be that there was a switch that they didn't want to confuse, or there could have been an irregular switch, that would be a second hypothesis -- again, that's complete conjecture -- that they -- they still had Bair Hugger devices that were being mixed with Mistrals so they didn't want to contaminate their results, and then when they purely switched fully over -- I don't -- I don't --
I'm making that up because that's just a hypothesis of an answer very carefully to your -- your question about 2014. If you want, I'll relook at this abstract to see if I can get a better answer for you.
Q. That's fair enough, doctor. I mean "I don't know" is a perfectly fair answer. However, if you do need to read that one page to answer any of these questions definitively, I'm happy to have you to do that in the next couple minutes.
A. Can I read this one paragraph?
Q. Go ahead. And I'll stretch my legs when you do that.
A. Okay.
Okay.
Q. Go ahead, doctor.
A. So I read the abstract and the best -- to my best of knowledge, the abstract says that they



switched in 2014, there is no knowledge whatsoever, but what it says is they used the 2013 group for the -- which would be pre -- before the 2014 switch, and they used the 2015, and we have no data on why they didn't include 2014. So some of my previous comments could be any or none of the reasons for why they didn't do that.
Q. You would -- thank you, doctor.
You would agree with me there are a number of limitations of this study; right?
A. There are a number of limitations of any published study.
Q. Including this one; right? And they even talk about some of them.
A. There are always limitations of any study.
Q. First, it's a very weakly-powered study; is it not?
A. I -- I didn't look at that part. If you want me to look at that, where -- where --
Q. Well can you look -- certainly. Can you look at the numbers, and they disclose the specifics in passing and then in detail on the second page. And my question: As you read those numbers, are they sufficiently powered to give you a definitive answer to the question?



A. Okay. Let me -- let me take a minute and read the "Results" section and then the next table.
Okay. I can answer.
Q. Thank you, sir. I'm ready.
A. I don't know where we're saying that -- necessarily that this is a weakly-powered study, unless you point that out to me, something that I missed in their methods. I think that I'm very happy with what I'm seeing here, that they didn't just look at infection rate, they actually adjusted to factors in a logistic regression model for age, gender, Charlson index -- that's C-h-a-r-l-s-o-n -- index score, which is an indication of morbidities, body-mass index and operative times, they did that, so I like the way that was done. I think that the --
What I'm really looking at here is this deep infection rate which was -- which was higher for the Mistral device, 20 versus 13. I can't tell you about the power of superficial infections or that. But to me we're talking about a study with -- with thousands of patients in it; the total number of patients are 5,400, so it's -- it's pretty good. Obviously, when you do studies like that, sure, we'd like to have as many patients as possible, but it would be pretty hard for me to imagine with that deep infection rate of

being .77 versus .47 in 2600 patients versus 2700 patients, that's pretty reasonably powered for that endpoint right -- right there.

Q. So let me ask you that. What -- specifically, what was the power of this study to detect differences in these two different groups?

A. I don't know the power.

Q. Okay.

A. I don't at this -- as I'm sitting here.

Q. Then I'm going to move on. I don't want to press on things you're not --

If you don't know, that's okay.

Let me ask you this: Did they use the CDC NHSN definitions of SSI and PJI in this study?

A. They would have used the --

I don't know which definitions you are referring to. They would have most likely used the MSIS -- which is the same group where this is being presented -- definitions of SS -- SSI and deep joint infections, but that's in concordance with the CDC. I think they're equal.

Q. Well what they say, doctor, as you partly stated, is that "Prosthetic joint infection (PJI) was defined as reoperation with arthrotomy or meeting MSIS criteria for PJI. Surgical-site infection" --



A. All right.

Q. -- "(SSI)" -- let me finish -- "was defined as a wound complication treated with antibiotics or irrigation and debridement."

And my question is: Does that comport with CDC definitions for PJI and SSI?

A. So I'll amend since -- since as --

I'm at a disadvantage because I haven't answered your questions and read this abstract for your questions, so I will amend my answer to say that I don't --

They obviously expanded their definition of infections to MSIS criteria, and then they added people brought to the OR and what you just read, and I can't -- we'd have to go and look at the CDC guidelines, which change, and see exactly how it corresponds for me to really answer that question.

Q. Fair enough.

Do you know what surveillance was done on these patients for SSIs and PJIs? I mean did they call the patients, did they see them in the clinic at 90 days, or -- or did they just see if there was evidence that they got readmitted, or do you know?

A. We have --

Well that's where you're asking me how we do



it. I've been here since 2016 and 2017 and we -- we -- we have a followup at three months of as high as anybody -- I can proudly say that -- we have a followup that's -- at three months that's like over 99 percent. Or I -- I won't say 99. Let's just say at three months we're like in the high nineties, we're as high as anybody not only in the country, in the world. And we're trying to get the six-month followup also close to that level at the present time. And that is pretty --

So that -- that's probably the best answer I -- I can give you. And there's tremendous quality control. And that's for the entire cohort of joint arthroplasties, hip and knee, that are done at Cleveland Clinic.

So clearly, the best answer is could there have been an infection that we missed? Yeah, that can al -- that went to another institution. But it's less likely because we do try to follow up a hundred percent of our patients, and typically the problem patients are seen and not ignored.

Q. But doctor, this is a retrospective analysis. This is the doctors, probably employing nurses or research assistants, going back retrospectively and looking at patient records, seeing



who was exposed to one product, who got which outcome, who was exposed to another product and got perhaps another outcome. And what I'm asking is: Did -- do you know what the process was for surveillance of this retrospective study?

MR. C. GORDON: Object to the form of the question.

A. Well I think I answered I don't know exactly that. If there were -- for example, if there were negative -- not negative values, if there were open values that they didn't have followup on X patient, did -- did they actively go and look at that? I believe, based on what they've done in past studies, they proactively went to make this data as robust as possible. What's --

That wouldn't be contained in an abstract, but you would expect that that type of information would be found in the actual paper of what percent followup, in answer to your questions, and I can't -- I could only surmise from what I know has been done in my year there and what I know has been done, because I -- I'm not just a year there, I know what they've done in their other studies, so that's why I am able to give you a little bit better than just simple conjecture.

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Q. Well that's why I'm asking you though. They didn't disclose that here specifically; did they, doctor?
A. No. So we're sitting here with a lot of the information that's me and you looking at this and trying --
Q. Right.
A. -- to surmise what they did.
Q. And another question I have on that -- on that same line is: Were these patients all cultured, or did they just go by their own review of the records and make a subjective determination of whether it was an SSI or a PJI?
Makes a big difference; doesn't it?
A. I -- I think that they are incredibly -- at Cleveland Clinic they are incredibly fastidious about looking at infection rates. This is an institution, not only for orthopedics but for every -- every department, this is an institution that is number two in the country and they want -- and a major part of that are infection rates, and they have quarterly meetings and they're looking at every single mini spike and looking at quality control and they're looking at different things like that. So it's not a simple thing of what you just said. They are -- they

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are fastidious at checking every patient and not just a few little blips in a retrospective study. This was --
In some ways you could say that this was all being done prospectively. This specific was -- right? It was prospectively collected data, but they -- they --
Another way to look at this is a ret -- retrospective review of prospectively collective -- prospectively collected data.
Q. Well doctor, I'm not sure I understand what that means, I mean "prospectively collected data." They're looking at the records and retrospectively extracting what was done to crunch their analysis and do their univariate and multivariate analysis. There's nothing in here that says they called these patients back in to do new testing; is there?
MR. C. GORDON: Object to the form of the question, --
Q. Is that what you're saying, --
MR. C. GORDON: -- move --
Q. -- prospectively collected data?
A. That's not what I said.
Q. Well what does that mean?
A. Well when the year is two thousand --

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Let's even go before the study just to turn this over. 2010 and '11 and '12, before the study, all these patients were being followed like hawks on a quarterly basis institution-wise, and they were doing their best to try to get like a hundred percent followup. I mean this goes to 90 days. I looked at this to make sure that we're not missing any infections; they're checking them out, they're keeping the quality control, they're very concerned about infection in this institution. That's why they are ranked very high. So therefore, prospectively there is a quality initiative that goes on that looks at every infection and characterizes them. Often it would go to me or a person in quality control, so it's not totally that we just retrospectively looked at a bunch of these and called people back.
Q. But it's fair to say, isn't it, doctor, that from this abstract, --
A. Yes.
Q. -- because it's all we have right now, we don't know if -- because they didn't tell us -- if they're looking at cultured pathogens versus subjective determinations of SSI versus PJI; do we? We don't have that evidence.
A. So I'm going to just answer that that for

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this abstract we have what the abstract says, and I would be -- just as I offered before to give you more information, I would be happy to go back, I would prefer to do it after he presents August 4th, and answer --
If you give me a list of questions like this, I'll be happy to answer, you know, any or all the questions you have. Just give me a list. I'll go right --
Q. Well doctor, you understand --
A. I -- I hear what you're saying. I'd love to be responsive to you and I'll answer any of these questions, but again, I have a bit of what you have on this abstract.
Q. You understand this is my day to take your deposition; right, doctor?
A. Yes.
Q. And I appreciate your offer to provide us additional information, and if counsel will let you do that, I'll be happy to get it, but it might involve reopening your deposition. Do you understand that?
A. Just as I've offered you, I have three other things where you've asked me for questions. I'm just offering this. I think it's up to the -- you and counsel to decide what you want to do, and I'm here to

help. If I have to be open to another deposition, I'm open to another deposition.
Q. Well we appreciate that, doctor.
I guess let's just end this discussion of this abstract with the agreement that there's a lot of information that neither one of us has answers to based on what we have in this abstract; is that fair?
MR. C. GORDON: Object to the form of the question.
A. I'm going to say I feel very comfortable with this abstract and the results because I know the quality of the re -- the two of the researchers -- no, three of the researchers and what they put out and how they did this analysis. So I feel, even though there are questions with this paper as there are with any published paper, any published paper, I feel very comfortable with what this abstract is saying and the message that it's delivering.
Q. And yet you in -- indicated earlier when we first talked about it that -- that you had concerns about the increased or apparent increased infection rate in some of the patients with SSIs found in this study; right?
MR. C. GORDON: Object to the form of the question.



A. It's just me looking at an abstract and seeing that that number is a little higher. I may not -- have concerns or I may not. I'm going to -- I'll come back after I've looked at this. Actually this week I said I'm --
I think maybe that's worth just a little query.
Q. In terms of your background, real quick, since this is a Stryker product, you do a lot of consulting work or work of one kind or another for Stryker Corporation; don't you?
A. Yes, I do.
Q. In fact, they've paid you well over a million dollars to date; haven't they?
A. Yes.
Q. What about DePuy, a J&J company, how much have they paid you to date?
A. They paid me indirect --
They paid me nothing to date, --
Q. Well they've --
A. -- the company. Indirectly, I've defended them in some of the metal-on-metal cases, if you want me to include that.
Q. When you say "defended them," you've testified in deposition and trial against patients on



behalf of DePuy in those metal-on-metal hip cases, like the ASR case; right?
A. Correction on my answer. I may have defended them or --
I was there as an objective -- as we said earlier -- as an objective witness, fact-finder, subject, person there to -- on their -- whatever you want to say. I don't want to get caught up in saying the wrong legal terminology because I'm not a lawyer.
Q. So how much have they paid you approximately? Is it over a million also?
A. No.
Q. Hundreds of thousands though; right?
A. Yes.
Q. Okay. Fair to say there are a number of other medical device companies and pharmaceutical companies that have paid you significant six-figure sums; is that fair?
A. Other than what we've just said here?
Q. Yes, sir.
A. Not --
One or two others maybe over the years in my past.
Q. Well there's some that you talk about just in terms of funding of your grants that are paying you



even through now, I think, tens of thousands --
A. Oh, that's what --
Q. -- per month, separate and apart from consulting.
A. Okay. So I didn't know what your question was. I thought your question was talking about me personally versus what is being paid in studies.
Q. Well --
A. So you didn't -- you didn't -- I --
Q. My apology.
A. My answer was personally. You brought up Stryker, as a consultant for Stryker, you brought up DePuy, and I gave you have an answer as an in -- I --
The real answer in DePuy is DePuy, I've never gotten paid personally from them, but through attorneys and through the defense of that. So I thought all these questions that you just started was for me personally.
Q. Then let's be clear.
A. Now you just pushed it into studies, --
Q. Let's break it down.
A. -- a separate discussion.
Q. Sorry, doctor.
MR. B. GORDON: I'm sorry, Dick.
Q. Let's break it down. With respect to DePuy,

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you have done testimonial work for them in defense of the ASR product, a metal-on-metal hip implant, and been paid hundreds of thousands of dollars personally for that testimony; have you not?
MR. C. GORDON: Object to the form of the question.
A. Yes, through a lot of trouble over a number of years. Yes.
Q. And --
A. It added up to that, yes.
Q. And you recognize that the DePuy ASR product was a defective -- was determined to be a dangerous and defective device for a lot of patients; right?
A. No, I --
MR. C. GORDON: Object to the form of the question.
A. I do not recognize that.
Q. It was recalled; wasn't it, doctor?
A. It was recalled. That doesn't mean it was defective.
Q. Well doctor, you know Tom Schmalzried; right?
A. I know him.
Q. He helped design that product; right?
A. Yes.

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Q. And you're aware that he testified that ultimately his opinion was that the device was defective.
A. I don't --
Q. Do you disagree with the designer?
A. I disagree with -- that he said that.
Q. Well doctor, he was paid millions of dollars to help design and promote that product; wasn't he?
MR. C. GORDON: Object to the form of the question, --
Q. Are you aware of that?
MR. C. GORDON: -- lack of --
A. He was definitely paid millions to design and I -- I guess promote. Yes, I would say yes.
Q. And he wrote -- he wrote white papers for DePuy on that product; didn't he?
A. He published papers. I don't know if he particularly wrote the white papers, but I would -- I would agree with you maybe.
Q. He ghost -- testified that he ghost-wrote white papers, which are marketing pieces, for Polly Carey and the other marketing directors at DePuy that were not peer-reviewed published papers; did he not?
MR. C. GORDON: Object to the form of the question.

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A. I'll -- I'll accept the answer because I know -- I did all that over a number of years -- I know who wrote the papers. I'm sure he had input in it. For you to say that he wrote those things, because I saw all the material that DePuy came out, I went through everything -- not everything, but a good portion of it, and I don't believe that he particularly wrote it. But I'm sure he oversee'd it, he looked at it, he analyzed it. Maybe he did testify somewhere that you have and I missed that, so -- but to the best of my knowledge --
But fine. If you want, I'll just agree with what you said. It's not a -- it's a small point.
Q. And doctor -- thank you, doctor. And it's nice that we can find agreement where we can. Thank you. So --
But you don't agree that the consensus of the medical community, the orthopedic community ultimately, was that the ASR was a defectively designed acetabular cup product, that the acetabular component of that product was determined to be defective by everyone who looked at it. You don't agree with that.
A. I don't agree with it.
Q. And you don't agree that the metal-on-metal

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meltdown, if you will -- let me -- let me -- let me withdraw that and start over.
You disagree that metal-on-metal articulations, which were once thought to be the way of the future, have now been roundly agreed as -- as being a disastrous result for the patient. You don't agree with that?
A. For which patients?
Q. For the patients who got metal-on-metal hip implants.
A. Not all.
Q. And you put in how many thousand resurfacing devices?
A. Several thousand.
Q. And how many of those were metal-on-metal resurfacing devices?
A. They were all metal-on-metal resurfacings.
Q. And when you first put those in, you thought they were the best product -- best orthopedic hip product ever created; right?
A. I thought they were an excellent orthopedic hip product for certain specific indications.
Q. And you've given YouTube video presentations in 2006 through 2009 about how great you thought various of those resurfacing devices were; have you

not?
A. I don't -- haven't looked at those lately, but whatever -- if I did --
There are some YouTube videos of me talking about resurfacing, that is correct, yes.
Q. And you promoted some of those devices for use in an off-label manner; did you not?
A. Yes.
Q. In so many words.
A. Well I -- I don't know if I --
Yes.
Q. In so many words. You -- you promoted those on YouTube for use in an off-label manner; didn't you doctor?
A. Well I don't know if I'm the one that promoted it because I didn't --
First of all, I never made a YouTube video, so -- somebody else did it. So you keep saying "you promoted it." I didn't necessarily promote it. I was on a YouTube video, I had an interview and I talked about it. If somebody asked me is this off label, I would have said yes, this is off label -- off label. I think that is a service to the patient by telling them you have to realize that this should be used for the right indications. And --



Q. So is it your testimony, doctor, that you didn't affirmatively raise that as a selling point, that this device can be used in an off-label manner? Is that your testimony?
A. You just asked me a few parts. "As a selling point?" What do you mean by "a selling point?"
Q. Did you or did you not have an interview on multiple occasions in which you affirmatively stated, without being questioned specifically first, that use of metal-on-metal resurfacing devices could and should be done in an off-label manner?
A. All right. I'm going to try to help you with the answer. Could be done in an off-label manner? Yes. Should? I don't know if that's said because I don't force people. "Should" is a bad word, so we'll leave that alone. For the right indications, maybe I said it.
In addition, you said "on multiple occasions." I believe that I was interviewed one time and that was cut in -- by the same lady, if it's what we're talking about -- I could be mistaken -- and that was cut into two parts. So in fact you said multiple interviews. I believe it was one time, cut into two parts, which may be two videos. I haven't looked at



this in a while. But I'm -- I could be wrong because it's not something I'm focusing on right now. These videos were done a long period of time ago. They may be over 10 years old. They're still up there, but --
Q. You don't dispute that you were interviewed and made statements promoting use of resurfacing metal-on-metal devices in an off-label manner before 2010; do you?
A. For a specif -- for a specific company, if they asked me, for example, about Wright Medical, I would have said off label because the cup was approved for use and the head was FDA approved, but off-label use is coupling the two together, and I would have said that. It's the same way that we use, for example, different medications, different devices off label; we let the patients know that. Not -- not all medicine is done on label. We --
Like aspirin for certain things is off-label use.
Q. But doctor, you were one of the pioneers in this country of using metal-on-metal resurfacings; are you not?
MR. C. GORDON: Object --
A. Yes, I was.
Q. And that's one of the reasons you were happy



to do these interviews and -- and promote these products, because you wanted them to become mainstream; didn't you?
MR. C. GORDON: Object to the form of the question.
A. I wanted them to be used appropriately.
And I don't know what you mean by "mainstream." I -- I did resurfacing, but in the same period of time at the peak of my doing resurfacing I was still doing way more standard non-metal-on-metal hips in a patient population that needs a hip replacement, if -- and we're calling a resurfacing a type of hip replacement.
Q. Well doctor, it says on one of your websites, doesn't it -- or maybe it was on Sinai's website -- and I quote, "Dr. Mont has been instrumental in bringing a revolutionary hip replacement alternative called metal-on-metal resurfacing to the United States," close quote. Do you dispute that that has been at least accredited -- attributed to you in the past?
A. I'll -- I'll accept that.
Q. And in fact --
A. I mean do you want me to read it?
Q. No. I -- you accepted it --

A. I accept it --
Q. Well if you accepted it --
A. I accept it as a general thing, yes.
MR. B. GORDON: Sorry, Dick.
Q. Let's move on if we can. And there was a time when you thought that you could get a 99 percent survivorship rate on these resurfacings out to 10 years; isn't that right?
A. I don't know if that's right. If I said that, I won't deny it. I would -- probably would --
You're saying "thought," so I'll hedge that. I think it's very --
When we get to 10 years for any person or device, it's hard to get 99 percent survivorship because -- because if a person got into a car accident on year seven, for example, and they had to -- got a fracture around the prosthesis, it would depend -- and that fails, that would count as a failure of the device. So it might depend on your definitions of what we call "survivorship."
If we include all survivorships of everything, including septic, which is pertinent to this case, aseptic periprosthetic fractures, to think that a population of patients are going to get to 10 years and 99 perc -- '9 percent of them are still



going to have it --
Q. Doctor --
A. -- is -- is hard. So if I said that, I'll hedge it a little bit.
Q. You --
A. I would like to think it was going to do very well.
Q. Do you dispute that you said, in so many words, that you expect to and believe you can get a 99 percent survivor rate for resurfacings at 10 years?
MR. C. GORDON: Object --
Q. "Yes" or "no."
MR. C. GORDON: Object to the form of the question.
Q. Did you ever say that?
A. I might or might not. I'm not sure.
Q. Fair enough.
You know as you sit here today, eight years later, that that's not accurate; right, doctor? You cannot get a 99 percent survivorship rate for any resurfacing device at 10 years; can you?
MR. C. GORDON: Object to the form of the question.
Q. Not even close; can you?
MR. C. GORDON: Same objection.



A. I think some surgeons have gotten very high -- let --
Let's not say 99. Let's say in the upper nineties, okay, because I don't -- if you want me to answer this right. Because remember, things get -- things happen to patients in a -- okay? So let's just say high survival rates in the high nineties.
We can look at registries, and if we looked at certain patient populations, some of them are doing better than total hip. So the answer to that at -- even getting towards 10 years --
I have a partner here at Cleveland Clinic that would probably say he's in the high nineties at 10 years with -- and that is Peter Brooks, B-r-o-o-k-s. And there are some people that are still doing resurfacings that get very high --
I don't want to use this term 99, and if I said that, I don't like using it now, so --
MR. B. GORDON: Objection, move to strike as non-responsive.
Q. Doctor, let me ask you this: You mentioned registries. We don't have a registry in the United States yet; do we?
A. We do have a registry.
Q. Well we have -- we have one that's been



started, but we historically have not had a joint registry maintained by the federal government in the way that the United Kingdom does and Australia does; do we?
A. We have an American Joint Registry. A lot of effort, time, a mega num -- a lot of patients are in it, but it -- and it's a more recent offering. Some of the data may not be as robust as what they have in the United Kingdom or some other countries. So in a general sense, yes.
Q. And doctor, are you aware as you sit here today of what the --
You studied all the DePuy stuff you told us; right?
A. Yes.
Q. So are you aware of what the 10-year survivorship rate is published in the United Kingdom, the British Joint Registry, for the ASR? Or the five-year data, whichever?
A. I know what the data was when they got to five years and six or seven for the ASR. However --
Q. Forty-four percent; right?
A. What?
Q. Forty-four percent failure rate; right?
A. No, it wasn't that. When it was recalled --

There is a recall phenomenon that occurs. When things get recalled, then everybody -- there is -- there is a phenomenon that occurs that -- that you get increased revision rates that may or may not be due to the prosthesis. And I have said that and that's been published, that type of phenomenon. It actually has a name that I'm forgetting off the top of my head, but it may just be -- "recall phenomenon" might be a name for that. So I will grant you that the revision rate of that prosthesis you're -- you just said 44 percent. I think that depends on what you're looking at, what population, who was doing it, what center, how -- how fast people are to revise things, the degree of surveillance, the technique. There's a lot of factors that go into those revision numbers.

Q. Doctor, orthopedic surgeons wouldn't revise a hip implant unless there was some kind of medical indication to do so; would they?

A. I can't always speak for other orthopedic surgeons.

Q. Would you?

A. Well I would never do that. But there is different levels of what people might consider is appropriate to revise. For example, some surgeons



might say if metal ions are elevated a little bit --

Q. What did Dr. Schmalzried say on that? What -- what was his threshold for metal-ion levels to indicate a need for revision?

A. I don't know what his --

Q. Two parts per billion; right, doctor?

MR. C. GORDON: Ben, let him finish --

A. I don't --

MR. B. GORDON: I'm trying.

MR. C. GORDON: -- before you step on him.

A. I don't know if he ever said two parts. I would love for you to show me where he said two parts per billion.

Q. Okay, doctor.

A. I don't believe -- first -- first of all that is -- would be --

Most people have two parts per billion -- or a level of two is what I think you're talking about -- that have metal-on-metals for an appreciable time, so he wouldn't say that a hundred percent of people that are asymptomatic, have no symptoms, at 10 years has a level of two, need to be revised. So I -- I don't think that's a correct statement for Dr. Schmalzried.

Q. Doctor, we can agree to disagree, but if I showed you testimony where Dr. Schmalzried changed his



view and indicated that his threshold -- perhaps in combination with other symptoms, I didn't say in the absence of other symptoms -- but that his threshold for a finding on micrograms per nanoliter -- that is, parts per billion -- of cobalt was two or greater as being a criterion for his thoughts on need for revision, that would surprise you as you sit here today.

MR. C. GORDON: Object to the form of the question.

Q. You don't think he said that.

A. I don't think he said that.

Q. Okay. Fair enough. We'll move on then. Fine.

A. No, he didn't say that.

Q. Let's -- let's just move past hips. The point I'm trying to make, doctor, or get your opinion on, is there are medical technologies, there are biomedical devices that have been thought historically to be great technologies that ultimately were determined not to be; isn't that fair?

A. There's many technologies like that, or devices, whether they're medical or non-medical.

Q. And sometimes there may be necessary technologies that are found to have problems later



that, even if they have a benefit, they have risks associated with them that are not known initially; isn't that fair?

A. The vaccines, some of the vaccines that were developed had risks at the beginning.

Q. Great example.

What about the heater-coolers that we talked about? You are aware that Sachs and Sommerstein and others identified, about three years ago now, a problem of contamination with heater-cooler devices. You've seen those papers; haven't you, doctor?

MR. C. GORDON: Object to the form of the question.

A. It -- it's not --

I've seen something like that, but it's not something I studied. So the answer is no. Why would I see the papers?

Q. Okay.

A. It's not -- it's not in my field of vision that we -- we -- we have a --

Sometimes I am aware of things that are outside my scope of practice, but in this case, no, I didn't see those papers.

Q. Let me read you a quote and ask you if you recognize this quote: "Adequate preclinical trials

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should be used to help identify some of the shortcomings of medical devices before widespread marketing of such devices to doctors and patients," close quote. Have you ever heard that before?

A. I think you're probably referring to something that I wrote myself.

Q. Do you know if you said that?

A. Sounds like something I might have wrote. I wrote -- I wrote a few papers on different devices that have been released, prosthetic devices by the way. I think that's -- you're -- you're talking about one or two articles I wrote on -- on -- on dealing with prosthetic devices that are released into the market, if that's what you are writing. I mean I think I'm not the only one that -- that wrote similar quotes to that. I might have been paraphrasing somebody else, or that could be what I'm the prime author of.

Q. It's not -- sorry.

It's not a controversial statement; is it, doctor?

A. No.

Q. And in fact, wouldn't you agree with me that if adequate preclinical trials had been done with respect to the Bair Hugger to try to identify some of

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its shortcomings before widespread use, we might not be having this conversation today?

MR. C. GORDON: Object to the form of the question, assumes facts not in evidence.

A. No, I disagree with that.

Q. Do you disagree that it might have been a good idea to use preclinical trials before mass marketing the Bair Hugger system?

MR. C. GORDON: Object to the form of the question, assumes facts not in evidence.

Q. Do you agree or disagree?

You can answer.

A. So -- so give me the question again. What did --

I don't disagree with that statement in general for any product.

Q. Fair enough. That's -- I'll take that.

A. Period.

Q. Let me ask this followup: If a company were to market a medical device without taking reasonably available measures to minimize potential safety risks, you as a doctor would be against that; wouldn't you?

A. I don't think --

I would be against it, and I don't think they would be allowed to do that in a general sense by

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different governing bodies, whether it's the FDA or whatever governing body is in charge of that specific device. Which, obviously, there are many different devices and many different governing bodies that have jurisdiction over those different devices.

Q. So, for example, if a manufacturer produced a device for use in the operating room around patients without fully investigating its potential for spread of contamination, that would be a bad idea; wouldn't it?

MR. C. GORDON: Object to the form of the question.

Q. Hypothetically.

MR. C. GORDON: Same objection.

A. That would be a bad idea.

Q. Thank you.

Talking about the Bair Hugger specifically now, did the company do anything, as far as you know, with respect to making representations to the FDA about the level of filtration on the device when it was first approved --

MR. C. GORDON: Object to the form of the question.

Q. -- or cleared? Have they told you one way or another or have you seen any documents concerning

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that issue?

A. I know a little bit about the MERV rating of 14. I know about -- I have read articles on what is required by different devices.

Q. Have you seen any testimony on that in any of the depositions in terms of --

A. I -- I haven't focused on that.

Q. Okay. Fair enough. I'll move on.

What about evidence of contamination of the Bair Hugger machines. Have you read studies or case reports or internal documents concerning whether the Bair Hugger or any parts of the Bair Hugger have been found to be contaminated with microorganisms?

MR. C. GORDON: Object to the form of the question.

A. I've read studies on that topic.

Q. Okay.

A. Multiple.

Q. And you are aware, then, that there is no disagreement that some Bair Huggers -- in fact a significant number of Bair Hugger devices have been found to harbor microorganisms.

MR. C. GORDON: Object to the form of the question.

A. I think every piece of equipment in the OR

harbors organisms. I don't know -- really understand the --

All right. The relevance of the question and some of those studies to me are -- are --

All right. We'll -- I'll just answer.

Q. That -- that --

A. You want me to just answer.

Q. Yeah. I'll move on. That's fine, doctor.

(Witness's cellphone dings.)

Q. So -- so since you mentioned other things, those are --

MR. B. GORDON: I'm sorry. You need to check that? Go ahead.

THE WITNESS: I'm going to just say "Will" -- just got to say "In deposition and will call later."

MR. B. GORDON: That's great, because I tell you, in the next 15 or 20 minutes I'll be at a good closing point for lunch maybe, so if we can finish this line of inquiry, then we can wrap up and take a break.

THE WITNESS: Okay.

Q. So to go back to that area, we talked a little earlier about exogenous or external -- whatever word you want to use -- sources of potential



contamination in the operating room. You remember when we talked about that?

A. Yes.

Q. And some of those that you mentioned are -- I think was the Bovie. What's a Bovie for the jury, doctor?

A. That's a cautery device that we use to -- when you have bleeding, it -- it heats up a few hundred degrees or more and a -- and a vessel that is bleeding, you hit the vessel with this device and the -- and the vessel will stop bleeding.

Q. And it's kind of like a zzzt. Is it a very intermittent kind of thing, or how would you describe that?

A. You would use it the least amount just to hit the vessel because you don't want --

It burns, it coagulates the vessel. You don't want to burn regular tissue that is normal tissue, so you minimize use. And it -- it's just one -- it's --

Q. It's one source of potential or -- or -- a potential contamination.

A. Source of heat, contam -- anything that's --

Anything in the OR can be a source in a general sense of contamination, some more likely than



others.

Q. And you mentioned a lot of those. Lighting you mentioned; right?

A. Yes.

Q. The lighting could have microbes on it; right?

A. Correct.

Q. And that's why you put -- on the handles, you put --

What do you put on them, condoms or gloves?

A. We -- we put light handles. I -- I personally like my lights adjusted. I don't use the light handles. I adjust the --

Q. It's a special thing.

A. I adjust the light handles before I start my cases, my knee or hip replacements, so the light's there. And I don't -- not only do I not want to -- do I not trust reaching up for these -- what you called this -- condoms, or they're -- they're hand -- they're -- they're -- they're devices that go over the handle that you -- that are packaged sterilely -- I don't like even the waving of the hand up to grab the light and adjust it. I think that creates waves that could be moving wind or particles that could be flapping into the wound. So you brought -- you



brought that example up --

Q. And -- and that's --

A. -- and that's why I don't -- I don't even use the light handles. I just adjust at the beginning of the day. It's my -- my thing.

Q. And -- and the idea is that you as, captain of the ship, the orthopedic surgeon in the operating room, are trying to do everything you reasonably can to minimize potential sources of contamination to the patient; right?

A. Yes.

Q. So what are some other examples? Let's just go through a few more. What are the --

A. The -- the -- the first source are the --

Well again, I've gotten criticized by what's number one, two, three, four, five. I don't want to say this is the first, it's the most important, so -- so I'm going to go into different sources.

I think of the -- the -- the people that are -- the surgeon and the team as a big source. You want to make sure you're -- you're disinfecting your hands to the best that you can, that you -- you put your -- your gown on. We have -- you do -- you put two -- I --

We use two gloves typically. You make sure

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you have the appropriate gloving technique, not only for the surgeon but usually two assistants when they're doing a hip or knee replacement. Also, there's a surgical person. So you're trying to minimize that, any breaks in contamination; that's just one of the things. If we --

The better way to look at it would be -- what I just said, would be to -- to organize this answer -- would be to say here's the patient walking in the room and what are they doing -- what are you doing first? Even before you get in the room you're clipping any excess hair. Often we use the night before and the morning of chlorhexidine, which is what I published on contamination, you're making sure about the patient doesn't have any sores on their body, things like that. Then you're going in the room, and one of the first things you're doing is applying disinfectants to the patients. If we're doing a hip or knee replacement, to their whole leg, and often you do two -- at least two coatings and you're waiting for that to dry because that's what the CDC says for effect -- effectiveness. So --

You're asking for other sources. So any of these are sources of infection.

You want me to keep going in all the

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different things --

Q. No.

A. -- that could be happening in an OR?

Q. I --

A. I mean there's so many different sources, you know, which we did on -- on this, quote, science day. The instruments, the saw blades. You mentioned -- you mentioned the cautery, the sucker tip.

Q. You mentioned the doors swinging open.

A. The doors going open, the amount of traffic, people -- the way the -- the gown -- the way the whole patient is draped, the way --

As I said, I don't like flapping. Are drapes being moved back and forth? Are the surgeons or the team, are they walking too much? And I say, "Stay still. Don't create all these winds and -- and currents." Are people coming in from the outside to deliver blood and they're -- they're creating currents? But these are all potential sources of waving air currents or creating heat --

Q. And in addition --

A. -- or --

Q. And I'm sorry I interrupted, but my question was kind of -- we've gotten a little off track, but I

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appreciate the explanation -- was really with respect to potential sources of contamination. It is your belief that each of those -- and put aside the patients and the -- and the -- and the staff for a moment -- each of those inanimate objects is a potential source of contamination that you need to try to avoid.

MR. C. GORDON: Object to the form of the question.

A. Well --

Q. Miti -- mitigate.

A. -- you need to use them all to do your case.

Q. So to mitigate their --

A. But you want to do the best you can to mitigate those sources that could cause contamination, yes.

Q. And -- and you listed a bunch of them, I don't have to go through all of them right now, you said in no particular order all these devices that you need to use in the operating room.

Do you need to use the Bair Hugger in the operating room?

A. You need to use the Bair Hugger or some type of device that maintains normothermia. That -- that's a normal temperature for the patient. We can define

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that and talk about that some more if you want --

Q. We may get to that --

A. -- in an OR -- in an OR setting.

Q. -- a little later, but there are other types, as you alluded to, since you brought that up, of -- of warming -- a patient warming that can achieve normothermia without forced air; correct?

A. Yes.

Q. And you've used some of those in the past; right?

A. Well there's -- there -- there's -- there's ancillary devices --

Just like you mentioned, just putting blankets on a patient keeps you warm a little bit. Is that what you're asking me?

Q. Well yes. You've used sources, if you will, or types of patient warming other than forced air successfully in operations in your career; haven't you?

A. Well in every hospital before here I used the Bair Hugger device, that I ever operated on, as the major -- as major device that maintains normothermia --

Q. Do you miss having the Bair Hugger?

A. -- until the Mistral.

Not necessarily.
Q. I mean you got the Mistral now because that's what Cleveland Clinic uses, but you just said you've been using Bair Hugger for how many years?
A. Well I started practice around '89, so --
Q. I mean are you disappointed that you don't have option to use the Bair Hugger now?
A. I just --
I don't know what your question is asking. I just want --
Q. I mean it's pretty clear.
A. -- a very effective -- I want an effective device that's going to maintain normothermia, so whether it's the Bair Hugger or this Mistral, assuming this is doing the job, I'm okay with that.
Q. Well let's ask that. Is -- is the Mistral doing the job? Is it -- is it warming as well or better than the Bair Hugger?
A. I can't give you that answer from -- from one or two studies. No, I'd have to --
Q. Have you talked to anyone at the Cleveland Clinic about whether they should consider letting you use the Bair Hugger?
A. No, I haven't.
Q. You used it for a couple of decades; is that



fair?
A. Yes.
Q. And successfully you believe?
A. Yes.
Q. What was your infection rate on average per year during that period of time?
A. Low. There were some years they were a little higher than others, and then we tried to identify. Some of them are even reported publicly in these papers I wrote. They --
Q. Sir --
A. -- at some times, and it depended on my patient composition, for primary joints they were well under one percent.
Q. So fair to say not zero.
A. Not zero.
Q. One percent. What's --
A. Some --
Well some years they were zero, so that's not true. So reported, some years were zero, some years might have spiked. Then we try to identify what that is. And that's why we did -- that's what led to me to doing a lot of the studies that you see in this report.
Q. Do you have any citations of authority or



evidence that you can point the jury to from your experience or review of the literature that demonstrates that the Bair Hugger was more effective than the Mistral system or any other for -- any other forced-air warming --
In fact let me back up. Ask another question.
MR. B. GORDON: Sorry, Dick.
Q. How many forms of forced-air warming are there?
A. I can't give you the exact answer. I know that I've seen in print -- because I haven't used these and I can get you the answer if you want later -- but four or five companies that have forced-air warming devices.
Q. There are more than that; aren't there, doctor?
A. Well I imagine there are.
Q. Internationally?
A. I don't know what's being used in Europe or Australia. But I don't -- I wouldn't know. Maybe that -- those would be exact -- there are --
Could be. My answer is if exactly there are four companies or five companies that have forced-air warming devices, I can't give you that answer.



Q. Let's take your number. Let's say there's five. Let's say there's Mistral, Bair Hugger and two other -- three others. Of those, do you know how many have a fil -- a HEPA filter and how many don't?
A. I don't know. I just know --
No, I don't know. I know at least one.
Q. Would it surprise you that the Bair Hugger is the only one without a HEPA filter?
Does it matter to you?
A. No, it doesn't matter to me.
Q. Okay. You would agree with me that forced-air warming is not the only means to effectively warm patients; wouldn't you?
MR. C. GORDON: Object to the form of the question.
A. It's viewed as a very -- as one of the most effective ways if not the most effective way.
Q. My question is: It is not the only means of effectively warming patients; is it?
MR. C. GORDON: Object to the form of the question.
A. Correct.
Q. Dr. Sessler's stated the same thing explicitly; hasn't he?
A. I don't know what Dr. Sessler --

I didn't read his deposition. I don't know.
Q. Well do you know Dr. Sessler personally?
A. I met him on one occasion.
Q. Your testimony is you haven't talked to him about this at all, Bair Huggers?
A. About what?
Q. About the Bair Hugger issue.
A. We talked about other studies, and the only thing is he mentioned that he had been deposed for five days about this case and that was --
Let me see if he -- if anything else was discussed. And then I basically told him I was -- I had been involved, and I don't think anything else. That was basically it. We talked about another -- a whole bunch of studies in my one meeting with him.
Q. But you did talk to him about the Bair Hugger case; didn't you?
A. No. I just said that I --
He mentioned that he had been involv -- to the extent of what I just said. We didn't --
There was no detail, so I wouldn't consider that talking about the case. He told me that he had been deposed for a five-day period, and I told him that I was involved. That's the --
Q. Has he --



A. -- pretty much --
That's not a hundred percent of what I discussed. We had a lot of things to discuss that day.
Q. Has he told you that he doesn't care how you warm patients as long as you warm patients?
A. I -- he didn't --
We didn't have that discussion, as I said, so I wouldn't know --
Q. In fact --
A. -- anything of what you're asking me.
Q. Sorry.
In fact, many other orthopedic surgeons use types of patient warming other than the Bair Hugger successfully; don't they?
MR. C. GORDON: Object to the form of the question.
Q. And you know that; don't you?
MR. C. GORDON: Same objection.
A. Other surgeons use other types besides forced-air warming.
Q. And some of them have very low, lower-than-national-average infection rates without use of the Bair Hugger; isn't that true?
A. I imagine some have low, some have higher.



Q. Okay. You talk in your report about the Bair Hugger and describe it as being far away from the patient or far away from the sterile field. Do you recall that?
A. Yes.
Q. How far away is the exhaust of the Bair Hugger from the patient typically in your operating room?
MR. C. GORDON: Object to the form of the question.
Q. And when I say that, in the past, obviously.
MR. C. GORDON: Same objection.
A. I can't give you an exact number, but it's -- I would say it's in feet, --
Q. And --
A. -- two feet or more.
Q. Is it your testimony before this jury today that a device that is -- that is within feet of the patient, it's okay with you as the orthopedic surgeon doing those ultraclean prosthetic joint surgeries to have a machine that has known contamination in the machine in that context? Is that acceptable to you as a surgeon?
MR. C. GORDON: Object to the form of the question.



A. I have machines that are within inches that have known contamination, and we have to deal with that. So this is well further away and draped off. It's so far removed compared to a number of other things that are within inches --
Q. And you're concerned about --
A. -- or -- or less in the field.
Q. Sorry.
A. I'm always concerned about everything, but not --
Q. Not the Bair Hugger.
A. It's so -- it's far removed and it's -- it's --
If I put on my list of concerns, if we say that anything is game, if we want to do it that way, then I -- I can probably make a list for you and put it as number 27 out of 28.
Q. Okay. So -- so it's on the list, it's just way down the list.
A. I wouldn't even put it on the list.
Q. Well you didn't in your report; did you?
A. I don't think it's operative.
Q. You put a litany of things on --
A. Some things, I think that if you -- I think that if you -- if you go into Burger King and you have

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a Big Mac, it doesn't make you fat, but if you had -- if you had one of those -- two of those a day, then you'll get fat, and so you don't say that the Burger King -- or the Big Mac causes you to be obese when you have one. And the same way, I don't -- I don't view this Bair Hugger as operative as leading to infections. It's not in there on the list. There are -- if -- as if --

It's like saying that the -- the garbage -- there's a garbage -- there's two or three garbage pails in every operating room and there's one like four feet away that we're putting things in there, that you could say all this stuff that's going into that garbage pail was contaminated, but I'm not putting that garbage pail on the list of things that are causing contamination for my patient even though I would rate that way higher than the Bair Hugger.

Q. Well you said a minute ago that anything is game and then you said it's 27th on the list, or way down the list. But it's still on the list. It's still game. You said that.

A. Well then I'll take that --

Q. Okay.

A. -- and I'll say I don't think it's game.

Q. So you're changing your mind -- you're --

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As we sit here today --

A. Yeah. As -- as I --

Q. -- you're changing your testimony.

A. Well it depends on what you're saying. Is something a one-in-10-million chance? But no, zero chance.

Q. Well --

A. So I'm going to change that answer. I have -- I reserve the right to say that I don't think it's operative in causing infections.

Q. Well the jury has a right to know why you're changing your answer. You -- you just said it's on the list, it's way down the list. And doctor, in your report you've listed more than a dozen things that are potential sources of exogenous contamination and the only one you haven't mentioned -- or the only two are the Bair Hugger and the heater-cooler devices.

A. No.

MR. C. GORDON: Object to the form of the question --

Q. Okay.

MR. C. GORDON: Wait, wait, wait. Ben, calm down.

-- and assumes facts not in evidence, mischaracterizes the testimony.

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A. So let's see how I would answer that. I am the one that sees patients that have these weird things, that the chances of it happening because of that is like one in -- I'd see the one in 10 thousand or the one in 10 million, these weird things that could have happened for this thing, but 99.9999 percent it didn't happen that way. And I'll just put something like the Bair Hugger is as close to zero as possible as leading to something that creates a bacterial infection.

Q. But not zero. Okay. Fair, doctor. Thank you. Let me ask you this.

A. The reason I'm going to say it's not zero, you have a device and what if the -- by accident -- this could happen in the OR -- the whole drape falls off that's protecting the patient from the wound, that could happen in an OR, and lo and behold patient moves in the middle of the case their thing and their wound touches, something like that. That's like a -- we could all it an act of God. So to say -- for anybody to say something -- some weird scenario couldn't happen --

But this isn't one of those 99.9999s, it's not in -- it's not operative. That's what I sort of was trying to imply. It's not one of those things

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that are really known or would be causative in creating an infection.

Q. So this is sort of the anything-can-happen idea. All these things you've listed, anything can happen. The -- the Bovie could become contaminated. But you do --

A. Oh, that's a real thing.

Q. Well the Bovie --

A. That does happen. That does happen.

Q. Do you have --

Did you cite any piece of literature --

A. Oh, yes. Oh, yes.

Q. -- that show me cases where the Bovie had became contaminated and caused an infection of a joint?

A. You don't need to --

The answer is, the first part, yes. I -- I cited literature that shows -- say -- I don't have the exact number, that Bovies are contaminated in 25 percent.

Q. Just like Bair Huggers are contaminated. They can be contaminated too; right?

A. No. But you're using a Bovie on a wound. The Bair Hugger is so far removed from a wound --

Q. You're using it on a wound --

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THE REPORTER: Just a moment.
MR. B. GORDON: All right.
MR. C. GORDON: Yeah. Let him finish his answers.
A. You're using a Bovie, which is contaminate -- this 20 percent contamination rate, that's why you have to be very careful. And often you may want to switch your Bovie tips during the case, which many -- many people do on a regular basis, because you're taking that Bovie and you're -- you're directly putting it into the wound directly where you're concerned. That's -- and that --
So you don't have to do studies that -- that -- that have to tell all the surgeons that we don't want to -- we want to minimize the chance of using things like Bovies and saws that get contaminated or things that fall on the floor, and then you put them -- you don't want to put that back in the wound. They're directly used in there. That's a far different scenario than you're saying that some of the -- the -- the -- the tubes in the Bair device have contamination, which is the same as all the other -- many of the other pieces of equipment in the OR anyway. There's no -- that's not a standard that -- that any of these other pieces in the device

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need a HEPA filter or anything more than what they're doing, and that any of that contamination that has been found on that device, which is not meant to be sterile, has anything to do with dissemination of bacteria or any problem whatsoever. And that's what I'm saying.
Q. Thank you, doctor.
You -- you need the Bovie to do surgery; right? Or to -- skin preparation.
A. Actually, no, not all the time. I -- no, I use --
Sometimes I use other cautery devices besides the Bovie. We're using --
Q. The ultrasonic?
A. We're using a PlasmaBlade now, and then we have this new Cat -- Canady device. So we're using -- we are actually using -- we're -- we're going to get on some studies with that and we're going to start -- I have few data on that. But the answer is you would want some device that minimizes bleeding, like a cautery or some other device, so the answer is yes.
Q. And so I understand and be clear so the jury understands, you don't use those actually in the wound; do you? You use them to cauterize a vessel. You don't actually stick them into an open wound; do

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you?
A. I don't --
They definitely go in the open wound. I don't know what you're asking me.
Q. Okay.
A. I mean you have --
The -- the vessel is not outside the wound, the vessel is in the wound.
Q. Okay.
A. Is that what --
Q. Yeah, I think that clarifies it for me. Do you --
The other things in the operating room that you've talked about, they are all essential pieces of equipment. Like lights, you got to have lights to operate; right?
A. You would not want to do these in the dark.
Q. Okay. So the point is you've listed a number of things that you as an orthopedic surgeon need to do your job that could be contaminated, but you want to minimize or mitigate the risk of that contamination; right?
A. Yes.
Q. Is the Bair Hugger absolutely essential to operate?

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A. What I said before is we're calling Bair --
I don't know what your question is. Is it Bair Hugger or device to maintain normothermia would be considered standard of practice by the CDC, any level, even the latest ruling by the --
Yeah. They just had a new guideline with that guy that I mentioned, Parvizi is like the middle author, that absolutely recommends maintenance of normothermia through -- through devices.
Q. And -- and those devices, just to be clear and go back to this, could be a number of different types of patient warming. Even Dr. Sessler agreed with that; right?
A. I don't --
MR. C. GORDON: Object to the form of the question.
A. You're asking me --
I apologize for the way I answered it. But you ask me a question, I'm about to answer it, and then you throw in this other clause.
The first part of your question is a yes. I have no idea what -- I've never read Dan -- is it Daniel Sessler? He has a father also that was a nuclear physicist. I think it's Dan Sessler. I have never read his deposition. I have no idea what he

thinks about this. So if you can --
Q. Well --
A. If you want to give it to me, I'll be happy to read his deposition, I'll do that afterwards if we want -- if everybody wants me to do so I can answer your questions better. Because he keeps popping up here.
Q. You're not aware that he's given presentations -- public presentations where he says specifically that he doesn't care what type of patient warming you use as long as you warm the patient?
A. I am not aware.
Q. And so my question -- underlying question is, doctor, --
(Witness's cellphone dings.)
Q. -- again, there are numerous different ways to warm the patient to try to prevent hypothermia --
THE WITNESS: Excuse me one second.
MR. B. GORDON: Sure.
THE WITNESS: I apologize.
MR. ASSAAD: Let's go off the record.
MR. B. GORDON: Yeah.
THE REPORTER: Off the record, please.
(Discussion off the record.)
BY MR. B. GORDON:



Q. Thank you. My --
Doctor, I was following up on that area about different types of patient warming. And you would agree with me, would you not, that the forced-air warming provided by Bair Hugger is not absolutely essential to be used in every orthopedic surgery; is it?
MR. C. GORDON: Object to the form of the question, asked and answered.
Q. I'm not sure you've answered that question; that is, is the Bair Hugger specifically required --
I mean you talked about this --
A. Is this -- is this the only device, is that what you're asking me?
Q. Correct.
A. It's not the only device.
Q. Fair enough.
Do you know who Dr. Kamal -- and I'm going to butcher this -- Maheshwari is? Ma -- it's M-a-h-e-s-h-w-a-r-i, first name is K-a-m-a-l.
A. K-a-m-e -- a-l.
Q. a-l, yes, sir. Kamal Maheshwari.
A. There is a Dr. Maheshwari that I'm a co-author on, but I believe -- my brain is not thinking. Because I haven't authored with him in a



few years. And he's at -- downstate in New York and his name --
Q. I'll help you out.
A. --is Atta -- Attatuck.
Q. This is someone else. So --
A. Oh.
Q. Okay. So you don't know a doctor of that name at -- who is an anesthesiologist at the Cleveland Clinic?
A. Okay. Now I have another question here. Kamal Maheshwari. So if you show me his --
Okay. So here's the deal. On any given Wednesday, as I told you before, I work with any -- from -- could be over 20 anesthesiologists. There are three or four that I primarily work with. And it's not ringing a bell, Maheshwari. Again, I would have mixed it with up with a guy I published with.
If you show me a picture of him, if you can get a picture on the internet, I can tell you whether I recognize him.
(Mr. B. Gordon displays computer screen to the witness.)
Q. Boom. Look familiar at all?
MR. C. GORDON: Now you got to put a little surgical mask on.



MR. B. GORDON: Exactly. A little cap. No.
A. Somebody like that with a beard looks a little familiar because he does -- somebody like that was asking me about doing a study, and then when I finally said we could do the study, then the company withdrew the support for the study. But I'm not that familiar. If it is that person, it's only about doing studies. I don't know what you're going to ask me, but I got it.
Q. Well are you -- are you familiar with guidelines utilized by the Cleveland Clinic concerning ventilation systems?
A. Guidelines --
Q. Standards or guidelines that are actually published in a book that is used by the Cleveland Clinic?
A. No. I -- I make an assumption, and if you want I'm happy to go through those, but I make an assumption that they are incredibly strict at the Cleveland Clinic about their ventilation systems. I don't know all the details about that. I assume -- it's a big assumption -- that they're safe. They've got a lot of ORs going at one time. I do --
In action, I remember one day where there was just a little bit of a defect in the wall that

happened over the weekend where there was like a damage to a wall, and they shut down the whole OR, one of our orthopedists. So they are to me obsessively compulsive about the details of what you just asked about everything. I've seen that with them. So there are people doing that. I'm just not involved in that.

Q. Have you ever opera -- I'm sorry -- designed an operating room manual for oper -- let me --

MR. B. GORDON: That's bad, Dick. Let me start over.

Q. Have you ever designed an operating room?

A. The closest I could say to designing an OR is when I would do surgery on animals in the '90s and we had to figure out which room we were going to use to operate on rabbits or dogs and say, "Is this ideal?" And I'd get an anesthesiologist and my vet and we'd sit there and we'd look at different rooms and say where do we think it's best. So maybe that's a facetious answer, but the answer is no --

Q. So would you --

A. -- in a general sense.

Q. Thank you, doctor.

Based on that answer, would you defer to experts on operating room design about the ventilation systems used in those operating rooms?



A. Absolutely.

Q. Okay. Fair enough.

You're not a member of ASHRAE. You know what ASHRAE is?

A. I -- I don't --

I can't give you give you the whole eponym, but yes --

Q. And --

A. -- that determines the standards for --

Q. -- NIOSH is another one.

A. I don't even know that one. I'm just --

Q. Okay. What about the American Institute of Architects who help design hospitals, you -- you a member of that?

A. No, I'm not a member of that.

Q. All right. Let me ask you if you -- if you agree or disagree with this statement. I'm going to give you two statements. Number one: "Infection control is critical in ORs." Agree or disagree?

A. Have to hundred percent agree.

Q. Number two: "Studies have demonstrated that most of the causes of wound contamination in the OR are the result of the patient's skin flora and bacteria shed on airborne particles from the OR personnel." Agree or disagree?



A. Let me write it down.

Q. I'll read it again.

A. "...most of the" --

Yeah.

Q. "Studies have demonstrated that most of the causes of wound contamination in the OR are the result of the patient's skin flora and bacteria shed on airborne particles from the OR personnel."

MR. C. GORDON: Object to the form of the question and the way you read it.

A. I'm -- I -- I -- I need --

Q. I read it slowly. I was trying.

A. Let me read it back to you because I didn't get the part --

Q. Sure.

A. Because I've got to analyze this because it's a --

"...most of the studies" --

Q. Well no. It just starts "Studies..." Sorry.

A. Oh. What's the beginning of it again?

Q. "Studies have demonstrated that most of the causes" --

A. "...that most of the causes of wound camin -- contamination in the OR are a result of



patient's skin flora or bacteria" --

Q. And bacteria.

A. "And" or "or?"

Q. It's "and" here. Yes, sir.

A. And bacteria.

Q. "...shed on airborne particles from the OR personnel."

A. On airborne particles.

Q. From the OR personnel.

Do you agree or disagree with that statement?

A. Wound contamination, patient's skin flora and bacteria shed --

So their skin flora or bacteria is being shed on airborne particles --

I can't even understand this. I have --

Q. That's okay.

A. I have a hard time with this.

Q. That's okay. You can't answer.

A. You've got a patient's skin flora is what I'm thinking, and bacteria is being shed -- that that's being shed into the air, and then it just says from the OR personnel, so it implies that the -- the OR person -- OR cre -- OR personnel are creating the shedding? Doesn't make sense.

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The whole way it's phrased, it doesn't totally make sense and is subject to different interpretation.
I'm going to keep trying to give you the benefit of the doubt on this statement. And I'm sure some authoritarian person said this or they're trying to make these statements, but boy, is this difficult.
Q. If you can't answer --
A. We're not -- we're not saying that -- infections, we're saying wound contamination, so you'd have to tell me what that means by "wound contamination," are a result --
Q. What does it mean to you? I mean you're an orthopedic surgeon. What does "wound contamination" mean to you?
A. Well this could be anything, just a bacteria or two, or it could be a whole -- something that leads to infection. They could be two different things.
Q. Well if it's just a bacteria or two, we're not going to worry about it.
A. Not always.
Q. Okay.
A. You would like to avoid that at -- if at all possible.
Q. Not a good idea to even get any bacteria in

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the wound, is it, if you can help it?
A. Well we -- we just --
What we want to do is minimize that as much as possible and dilute everything as much as possible. There clear --
Clearly, there are colony-forming units in every OR.
Q. Doctor, the point of this --
A. You just can't have zero. But I mean that's such a -- this is such a weird statement that I have trouble reading it. I -- I don't know what --
Q. Well let me ask --
A. If this was the case, if this was truly the case, then why wouldn't we have every OR personnel -- why I don't totally agree with it -- why wouldn't we have every OR personnel that is even working in that OR -- which is not the case -- that even walks in there completely scrub? Why wouldn't we have -- and there was a study like this. Why wouldn't we have people prepping the leg, which could be one or two, completely as sterile as possible in their gowns?
Q. So you're not --
Is it your testimony you're not concerned about airborne particles around the patient at all?
A. I'm definitely concerned.

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Q. Waving your hand, you said you try to minimize that, right, for that very reason?
A. I didn't say I wasn't concerned.
Q. You don't leave the windows open, do you, in the operating room?
A. Part of this is this "most" and --
Q. Most of --
A. -- some of it I don't know and some of the way this is phrased --
Q. You'd be --
A. So I don't have a problem with --
Excuse me. Can I just -- I just want to --
I'm concerned about all these things.
Q. You're concerned about air particles around the patient; aren't you?
A. Sure.
Q. Of course. You -- you don't leave the window open to let the breeze blow in; do you, doctor?
A. What window?
Q. Any O --
I'm sorry.
A. We wouldn't --
Q. You don't have operating rooms with windows; do you?
A. No. We sometimes have operating rooms --

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But we --
Q. If -- if -- if you have --
A. -- we don't do that. I agree.
Q. If you have an operating room with a window, you keep it closed during surgery; right?
A. Yes.
Q. Because you don't want particles or debris or pollution or anything blowing in in a sterile environment; right?
A. As an anecdote, if a fly or anything walked in an OR, everything would have to be shut and you'd have to get rid of that fly and close -- you know, cover --
I mean it's like a whole thing.
Q. You don't smoke cigarettes in the OR.
A. It doesn't happen too often, like once every five years.
Q. Let me ask you this. You've been around a little. Were you around back in the day when I've heard anecdotally that some of the people in the OR would actually light up a cigarette?
A. I couldn't even conceive of it. It's never been in my --
Q. Never seen that?
A. Never. Never been in my frame of reference.

Q. Certainly wouldn't be allowed today.
A. Yeah. I mean it's not even in the ballpark.
Q. Yeah. Striking a match would be same thing. You'd have to shut down the OR; wouldn't you?
A. You don't --
There's so many things that could lead to a fire in the OR, not only --
I mean when I said that three-minute thing with the alcohol and the prep, they're concerned with everything. A Bovie coming in contact with a prep with alcohol that could lead to a fire. So they are very ultraconservative about all these things.
Q. Doctor, we're going to take a lunch break. Before we do, I want to ask you one just very quick line of questioning.
Somewhere in your report or in these papers you indicated that, I think -- tell me if this is wrong -- that you do about 80 percent of your testifying for industry and about 20 percent for plaintiffs. Is that about right?
A. Industry?
Q. Well --
A. Say it again.
Q. -- defendants. About 80 percent for defendants, about 20 percent for plaintiffs?



A. Something like that.
Q. 80/20. And the 20 percent for the plaintiffs --
A. Wait, wait, wait. For -- define --
The plaintiff, we're talking about a --
Q. That's what I'm asking you.
Sorry.
A. All right.
Q. I want to know what you mean by plaintiff.
A. In that type of answer, it would be 80 -- it would be the type of case where a physician is being sued. There -- there's a middle ground where I'm just called as an expert on a topic, like I'm an expert and I'm not for either side. That happens. I'm a osteonecrosis expert, they call me for both sides. "You're an expert. We want to hear on these things." But in cases where I'm defending a doctor, let's call it that way, or am I on the side for a patient taking a case, it's about 80/20.
Q. So it's your testimony --
A. Which -- which I think -- I think holds up in that list I gave you. You know, a small part of my life, but there was a list of 20 cases. If we looked at that, I could actually tell you what that number is from that list of 20, which was compiled over four



years, and since then I haven't really done much.
Q. Let's take --
A. One or two.
Q. -- a look at that, doctor. Find that exhibit for me there. I've got a -- my copy, but there's a marked copy. You can look at that one.
A. Yeah. So this would be --
Q. Eleven cases.
A. So right. And the reason I brought it up, most of the time I'm defending doctors --
Well one of them is just a worker's comp case. That's number three.
Q. So Judith Cherrak, number three, --
A. It's a worker's comp.
Q. -- you were testifying then as a treating doctor for this patient?
A. Treating doctor. And they wanted to know if she should be out of work X period of time.
Q. So let me ask you about that, doctor. Was your opinion in favor of the patient and her disability, or contrary to that?
MR. C. GORDON: Object to the form of the question.
A. It was in favor with a lot of provisions, because they --



They were happy with me, but ultimately they weren't wholly happy with me. They wanted to do a lot more, if you want -- if you want, the patient and their lawyer. But they -- they had what I felt was the truth.
Q. Who was the patient's lawyer?
A. I don't remember.
Q. You don't remember?
A. Just one quick deposition. It took two hours. And they wanted to claim that X was due to her injury, and some portion of it -- she had like partial liability due to the jury. But it was --
They probably would have wanted me to say that all her disability was due to this injury, and I basically said some percent that I felt was due to the injury and some percent was pre-existing condition.
Q. Who was her employer?
A. I have no idea. I don't remember this.
Q. Who noticed your deposition? Who --
Did the plaintiff's counsel notice your deposition or did the worker's comp counsel?
A. I don't know.
Q. Okay.
A. I don't --
I mean this is not a big part of my life, so

something like that --
Q. Any other --
A. I do not have the records of this.
Q. All right. Let's move on.
Any others of these 11 --
A. I'm -- I'm --
Q. Let me ask my question. Any others of these 11 where you testified on behalf of a patient?
If you want, I'll narrow it, doctor, and save time. There are five cases I'm most interested about, there's five trials if I'm counting right. In those five trials were you testifying on behalf of the patient or the doctor or someone else?
A. Number one is the patient.
Q. Okay. So Ms. -- I'm sorry. Heather Carter versus Loucks, what kind of case was that?
A. That was a --
It was a purported malpractice against a surgeon --
Q. And you --
A. -- and I was -- I was representing Heather Carter in that one.
Q. The patient. And how did that end up?
A. I don't know. They were going to appeal it or something. It -- it did not --



Q. So she lost her case?
A. Yes.
Q. Okay. Next?
A. Mingo versus DePuy is -- is one of those ASR cases.
Q. You testified for DePuy.
A. Yes. I'm --
Q. Okay.
A. Or we're just going to say for the truth on all these things. But then --
MR. B. GORDON: Object, non-responsive.
A. -- who is --
Q. Your testimony was on behalf of DePuy.
A. The lawyers that represented DePuy, yes.
Q. Your testimony was to defend DePuy's medical products; was it not, doctor?
MR. C. GORDON: Object to the form of the question, asked and answered.
A. I don't have an answer to that.
Q. Okay. That's fair enough.
A. I'm here for both sides.
Q. All right.
A. Say it that way.
Q. Any others where you testified on behalf of the patient, like with Ms. Loucks, out of these 11?



If you don't remember, that's okay, doctor.
A. The only one --
I think all the other ones are in behalf of a surgeon or doctor, not --
I can't remember Wade off -- off my head right now.
Q. So with respect to the last four years at least, the 80/20 doesn't hold true, it's more like --
A. Well this is only --
Q. -- 10 to one.
A. This is only a sampling of 11, and I told you -- what did I say earlier -- 60.
Q. This -- this is -- I'm sorry. This is only 11 --
A. It's not even 11, it's 10, because the number two is the -- is the DePuy case, and number --
It's not even 11, it's -- it's at best nine.
Q. What I'm trying to understand, doctor, is this list is 11 cases where you testified by deposition or trial since June 1st of 2013. What am I missing? Is that not right?
A. No. This is from '13 to '17.
Q. Right.
A. I haven't been doing that much. I haven't done any --



This is the first time I've been here this year and I'm not -- don't plan --
I'm the chairman of Cleveland Clinic. I'm not doing too much now and I've slowed this down. What I'm telling you is I've done 60 or so. You have a sampling here of nine -- 10 or nine. Mingo versus DePuy doesn't count. That's a separate category. And number three is a -- is what -- is a disability. I gave you a number of 60 where it's a decision plaintiff versus defendant -- or let's say -- I'll lower it to 50. This is only a sampling of nine.
Q. Okay. So this --
A. So I would still say the 80/20 holds up, if you're trying to say that it doesn't hold up.
(Mr. Assaad tries to get Mr. B. Gordon's attention.)
MR. B. GORDON: I'm done. Just let me finish, Gabe. If you want to walk out, step out. Quit interrupting me.
A. If -- if the implication is that I'm not doing 20, I am doing about 20. I know that there could be two in a row. Sometimes it's not a physician, it's an ER or it's a situation.
Q. All right, doctor, I'm trying to understand, I'm just -- and let's to go lunch, but the question

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I'm not clear on is these 50 or 60 you're talking about, are we talking about in the last four years? Because all I want to know about is the last four years.

A. No. This is career.

Q. Correct. That's what I want to understand.

In the last four years you've given us all the cases that you testified in, the 11.

A. Okay. So my 80/20 would have been lifetime.

Q. Understood.

A. If I implied otherwise in a previous answer, it's a general number. These are the cases, to the best of my knowledge, that I was able to collect over the four-year period. It amounts to 11. Of those, nine -- I don't -- I -- the last two I'm a little questioning of, but I'll give it as ones that I defended doctors. I can go back and really defin --

I might be able to go in my computer. I'm not sure. A lot of it I got rid it. So we'll say of those cases it's one versus eight -- one out of nine.

Q. That's all I was trying to clarify.

A. Okay. You got it.

Q. So in the last four years, the cases that we've got on this exhibit, it's only one out of nine or 11 on behalf of patients, so the -- just so it's

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clear.

A. Well my own patient is two out of 10, --

Q. Okay. Two out of 10.

A. -- Carter and Cherrak.

Q. Okay. Doctor, you're not an infectious disease doctor; are you?

A. No.

Q. You don't hold yourself out as an expert in microbiology or infectious disease?

A. I don't hold --

I hold myself to the extent, as an orthopedic surgeon, I have to deal with infections and have published a lot on infected hip and knee replacements, which are relevant to the case, to that extent I'm to some extent an expert. As a -- as a pure infectious disease person, microbiologist, no, I'm not an expert.

MR. B. GORDON: Fair enough. Thank you, doctor. We can take lunch.

THE REPORTER: Off the record, please.

(Luncheon recess taken.)

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AFTERNOON SESSION

MR. C. GORDON: And I just want to note for the record that we understand that Mr. Gordon, Ben -- Mr. Ben Gordon has unexpectedly left and Mr. Assaad is going to -- has indicated he's going to take over the questioning. We think this is irregular and inconsistent with the -- with -- with the practice if not specific rules, but I've also indicated in order to finish this out we're going to let Mr. -- Mr. Assaad go ahead and ask -- ask questions.

MR. ASSAAD: Thank you, Mr. Corey Gordon. I'm going to say "Corey Gordon" because I don't want to mix the two Gordons.

MR. C. GORDON: Now it's easy. I mean I'm the only Gordon in the room.

(Discussion off the stenographic record.)

BY MR. ASSAAD:

Q. So Dr. Mont, we have met before; haven't we?

A. Yes.

Q. Actually, one of the cases you listed on your deposition or trial list is a case of Victoria Smith, and we met at trial.

A. Smith versus Moskowitz.

Q. Yes. All right. I don't recall, but I think I was the one that actually cross-examined you

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at trial.

A. Yeah. But now that I'm thinking about it, maybe there -- you both were doing it.

Q. Maybe.

A. I mean I think you tag-teamed that one. Right? You came in like a little later.

Q. It's my new -- it's my new MO I guess.

A. I think there were more than one.

Q. Yeah.

A. I think you were --

Q. So --

A. That's why, when you said that, I seemed to remember it. But I don't -- what do I --

I don't remember all these cases. I'm surprised I remembered --

Q. First thing, sir, I want to go to page two of your report, Exhibit 5.

A. Okay.

Q. It's right there.

Now you wrote this report and you submitted it around June 1st or 2nd; correct?

A. Somewhere in that vicinity.

Q. Okay. And --

A. Well it was being written like a week or two before.

Q. Okay.
A. Final, it was handed in in those days.
Q. Fair enough.
And when you wrote this report, I mean you -- you checked it for accuracy to make sure everything was correct.
A. I did to the best of my ability. Since then I found a few typos or things that --
Q. Forget about --
Substantively.
A. -- I might -- I might change.
Yes.
Q. And as you testified earlier, this -- this report, which was due by -- by June 2nd, is the totality of your opinions as of the date of filing this report; correct?
A. Depends on, I guess, what are considered the most relevant things. I mean I have other opinions, but --
Q. Okay.
A. -- that -- that your side should know.
Q. Fair enough.
We talked about how many surgeries you did previously per year and how many you -- patients you see per month, and you wrote in your report on page



two, "I routinely take care of lower extremity joint arthroplasty patients. I have performed during my professional career over 500 to 700 joint replacement surgeries per year for a total of over 15,000 since 1999."
I take it that was at the time you wrote the report; correct?
A. If you read the last phrase in that paragraph, that's not true. It says -- look in the paragraph there, it says "...(although with duties as Chairman this past year, my clinical activity has been reduced)." So what this is referring to is -- is factually right.
Q. Okay. So --
A. Not every year did I do 700 surgeries. At the beginning of my career I was doing closer to 500. The later part of my career I was doing closer to 900. I'm giving a general average since 1990.
Q. Up until you went to the Cleveland Clinic?
A. And then -- and then what I said, actually I didn't even realize it says here, so 6,000 was a more factual -- what I said earlier in -- today --
Q. Okay.
A. -- was more right. But if you see the last parenthesis, when I become chairman, the clinical --



Let's call clinical 50/50 now. Okay? So whatever number is there, it should be three thousand and --
But that's not even right. I was doing -- I did 865 cases -- I'll do about 400 surgical cases, and I'm seeing, I think, a little over 3,000 cases by the last numbers. And we -- we get the numbers every month to see.
Q. How long does it take you to do a total hip on average?
A. Skin to skin, about -- we're talking about somebody that does not markedly have a high BMI -- about twenty -- the average would be about 22 to 24 minutes.
Q. To do a total hip?
A. Without rushing. Yes.
Q. Okay.
A. Skin to skin.
Q. What about a total knee arthroplasty?
A. Total knee, a little bit longer. I would say about 40 to 45 minutes. So --
Q. Okay. And -- and all those --
In all those cases you used some sort of device that maintains normothermia?
A. All of those cases.



Q. All. So you --
And while you were at the -- in Baltimore, that device was the Bair Hugger forced-air warmer; correct?
A. If not a hundred percent, then I would say 99.99.
Q. Okay.
A. And maybe there was an exception, --
Q. Do you know which Bair Hugger --
A. -- but few.
Q. Sorry.
Do you know which Bair Hugger device you used?
A. I know there's a lot of different models or things, but I can't tell you that.
Q. Okay.
A. I can find that out if you want later.
Q. And the blower of the Bair Hugger, that's placed next to the anesthesiologist; correct?
A. Yes.
Q. Underneath the operating room table; correct? Underneath the head of the patient.
A. If we put it underneath the operating room table, that would be like on the floor. No.
Q. So --

A. At the head of the -- at the head of the table.
Q. Was it on the floor or on a pole, if you know?
A. It would be over the patient --
Oh, the actual --
Q. Blower.
A. Yeah. The device would be -- I guess would be on the floor.
Q. Okay. And that device would be close to the anesthes --
A. I'm thinking of what's attached to the patient.
Q. And that's why I referenced the blower. The blower is on the floor; correct?
A. Yes.
Q. And the blower is placed underneath the head of the -- usually around the head area of the patient, on -- on the floor.
A. Yes.
Q. Okay. You don't hold yourself out as an expert on normothermia; do you?
A. I don't know what that question means. I -- I mean I've read a number of articles on nor -- normothermia in preparation for this -- this case. I



don't know if there's any person that would call themselves --
It's not a subject in medical school that you study.
Q. I understand. But you know Dr. Sessler and Dr. Kurz have devoted their life to doing research in the areas of maintaining normothermia.
A. I couldn't tell you that they devoted -- it doesn't seem --
Having met Dr. Sessler one time, I don't think he spent his whole life, --
Q. Okay.
A. -- has devoted his life. I wouldn't charact -- he -- he has a -- in the --
In the role that I have at the Cleveland Clinic, he's the director of -- one of the directors of research at Cleveland Clinic. I don't know the exact title. He also oversees research for the whole anesthesia department. I was getting involved with some other studies that are not related to this one, so that's why the meeting was. But I think he's also -- I -- I don't know --
Q. Okay.
A. -- if I would say --
Q. That's fine.



A. -- what you said.
Q. And to speed things along and -- I mean if you disagree, you don't think he's an expert, just say "I don't think he's an expert" and let's move on.
So I want to turn to page 17 of your report.
A. So -- so should I --
Q. You cite -- you cite Dr. Kurz and Dr. Melling as -- as citations for strong evidence of SSI reduction for active warming. Do you see that in your report on page seventeen?
A. Wait. I didn't say that Dr. Sessler is not an expert in -- in hypothermia.
Q. You just didn't --
You didn't know.
A. I mean he's published on it.
Q. You didn't know.
A. Well I know he has publications on hypothermia, so we're level with that. Okay. So let's --
What's this question? I'm sorry. I apologize.
Q. Now you -- you cite on page 17 the Kurz article of 1996 and Melling -- Melling article 2001 as -- to support your statement that strong evidence of SSI reduction for active warming was found. Page



17.
A. Okay. Okay.
Q. Do you see that?
A. I see that.
Q. Okay. Have you read those articles?
A. To the best of my ability, not recently, but yes.
Q. Okay. Are you aware whether or not Melling supports the proposition --
A. Yeah.
Q. Do you -- do you under --
Do you understand that Mellon -- Melling deals with prewarming and not perioperative warming?
A. Yeah. Melling -- Melling is -- well Melling is on pre -- the whole --
Q. Yeah.
A. The whole article is on prewarming.
Q. Okay. And that's different than perioperative warming; correct?
A. Well it depends on your definition. You can call everything perioperative.
Q. Okay.
A. So I mean I -- I don't want to get lost in semantics. But I'll -- I'll agree with you. I mean if you want -- I --

I wouldn't hang up my whole argument on the beneficial effects -- which is what this is -- on those two articles alone. I think there's a lot of articles, if you want to hang up -- hang on those two articles. If you want to delete those, I could give you others articles. But that is prewarming.

My life, I view prewarming -- the whole part as part of the perioperative period.

Q. Do you know whether or not the -- the study in Melling dealt with warming patients while -- before or after the incision?

A. No. I don't want -- I don't want to rely on memory for --

Q. Okay.

A. -- any of these. I mean for some of them I will rely on memory. And I apologize for saying this: Even my own studies where my name is the lead author, I don't want to rely on memory in answering specific questions like that. If you --

I'm very happy to answer this later, or if you want to pull up the article right now, we'll go and look at it.

Q. Well let's just --

The article states what it states; correct?

A. Of course.



Q. Okay. And -- and --

A. Based whatever --

If you say that, then I agree that --

Q. And you're aware that Kurz -- you're aware that Kurz dealt with colorectal surgeries; correct?

A. I would say --

What I would say, it's not orthopedic, yes.

Q. Okay.

A. I - I don't know which one -- and some --

I don't want to mix up ones on colorectal, ones on cardiac.

Q. Sitting here today, are you aware of any study that indicates that maintaining normothermia during the perioperative period reduces the incidence of a periprosthetic joint infection?

A. Any orthopedic study.

Q. Any study that indicates that maintaining normothermia during a -- a total hip or total knee arthroplasty reduces the incidence of periprosthetic joint infection.

A. You just said "any study," but you said periprosthetic, so we're talking -- can't say "any." It's --

We're talking about total joint studies, hip or knee arthroplasty.



Q. Whether it's done by anesthes --

A. Periprosthetic means prosthesis.

Q. I understand what it means, sir. My question is: Are you aware of any study from any discipline that -- that supports -- strike that.

Are you -- do you rely on any -- strike that.

Are there any studies that you're aware of that indicates that maintaining normothermia during a total hip or total knee arthroplasty reduces the incidence of periprosthetic joint infection?

It's a simple "yes" or "no."

MR. C. GORDON: Well --

A. Well I'm scanning my memory bank here.

Q. Okay.

A. And it's not a simple "yes" or "no." We know that there's a lot written. For example, the consensus statement by that Parvizi group with the book, there was a 92 percent concurrence that using -- maintaining normothermia would reduce the in -- was -- was believed that that would reduce the incidence of periprosthetic infections. Most -- they did say in the conjecture that most of the -- that's why --

The evidence was from three or four studies that were non-orthopedic, in that -- in that statement



which came out, I guess, in '14, okay, so that was --

Q. You mean the one that came out in 2013, the International Concensus?

A. The International Concensus. That's a book --

Q. Do you think that's authoritative?

MR. C. GORDON: Let him answer the question. Just hold on.

A. I think that's very authoritative.

Q. Okay.

A. That's -- that's what a lot of us are going by. And there's going to be another meeting of the 400 experts in -- and we're not talking about the CDC, we're talking about what you -- in one of your parts of your question you're asking about periprosthetic joint, prosthetic meaning joint. So they did say that there was a lack of studies in orthopedic literature, but based on the studies that were non-orthopedic, 92 percent or maybe higher felt that maintaining normothermia was important to reduce the risk of infection.

There was another CDC statement that came out saying similar things. There may be -- I don't want to say the wrong thing. And, you know, I do recall the study in Orthopedics on hip fractures by

Frisch that showed a lower periprosthetic infection rate. The -- I have --
Q. So first, how do you spell Frisch?
A. The last name is F-r-i-s-c-h.
And I would have to get back to you on that, because sometimes --
Q. Sir, I understand that you keep on saying you have to get back to me, but today is the time I take the deposition. This is your report and it's certified; correct?
Let me ask you this: Have you cited --
Is there any study in Exhibit 5 that you could cite to that -- that claims that maintaining normothermia reduces the risk of periprosthetic joint infections?
A. Let me look through Exhibit 5, because I don't want to give you the wrong number.
Q. I'm not talking about --
A. Exhibit -- this -- this exhibit.
Q. No. Exhibit 5, your report.
A. This is part of Exhibit 5.
MR. C. GORDON: Well --
Q. No, that's --
MR. C. GORDON: He separately -- separately marked the reference list --



MR. ASSAAD: Okay.
MR. C. GORDON: -- as eight.
MR. ASSAAD: Withdraw the question.
Q. You've studied periprosthetic joint infections; correct?
A. Yes.
Q. You've actually done studies and have published on the issue; correct?
A. Yes.
Q. And you --
And sitting here today, you can't cite a study without looking at Exhibit A, off the top of your head, of any study that shows that normothermia reduces the risk of periprosthetic joint infection.
If you can't, you can't, sir.
A. For a real answer, there are some things that if it's already been confirmed in other specialties, it would be unconscionable -- by all three definitions of the word -- to actually do a study would be unethical, unconscionable. You couldn't get patients to do a study like that. And because of all the problems that not maintaining normothermia would ensue, there wouldn't be a study like that. In addition, we know that the lack of normothermia will lead to hematomas and bleeding



risks, all of which lead to infection.
Q. That's not what I asked you. Let's stick to -- let's stick to --
A. But I -- no.
MR. GORDON: Let him answer the question.
MR. ASSAAD: Corey, you -- you understand where he's going here.
THE WITNESS: But I'm --
MR. ASSAAD: You know what he's doing.
THE WITNESS: But I'm not --
MR. ASSAAD: I'm asking about -- I'm asking you about --
THE WITNESS: But I'm not here to answer --
THE REPORTER: Off the record. Off the record.
(Discussion off the record.)
BY MR. ASSAAD:
Q. Sir, I'm specifically -- I want --
I'm going to ask you questions and I want you to answer the question that I ask you. I asked you about periprosthetic joint infection. I did not talk about hematomas, I didn't talk about any other issues. I asked are you aware of any peer-reviewed literature that indicates that maintaining normothermia reduces the incidence of periprosthetic



joint infection?
That's either a "yes" or "no."
MR. C. GORDON: Hang on. Gabe, it's -- you're not going to get to instruct him whether your question is "yes" or "no." He's going to answer the question the way he feels fit.
I think the answer that he was giving when you interrupted him was directly answering your question. You may disagree. You have the right to move to strike after he has finished with his answer. That's the way it works. If nothing else, as a matter of courtesy to the court reporter.
MR. ASSAAD: I --
MR. C. GORDON: If you -- if you want to be courteous to the witness, wait until he's done with his answer. If you don't think it's responsive, move to strike. But let's have a little decorum here.
MR. ASSAAD: I understand that, Mr. Gordon, but I'm asking a specific question of whether he's aware of any pub -- peer-reviewed literature that supports -- or indicates that maintaining normothermia reduces the incidence of periprosthetic joint infection. If he's --
He could say, "Yes, this is the literature," or, "No, not right now. I don't know what it is."

So --
MR. C. GORDON: Okay. You know, Gabe, I just want to point out, in that question you asked "literature that supports." He was giving you a -- a -- a fairly detailed explanation of the literature that supports normothermia's relationship to periprosthetic joint infection. You may not like it, you may not think it's responsive, that's fine, --
MR. ASSAAD: I want --
MR. C. GORDON: -- just let him finish.
Q. So -- so I want the name of the literature.
A. So I'm -- I'm not going to -- to --
My answer is normothermia promotes tremendous health benefits to the patients that have been studied outside of orthopedics. I would have to look specifically in ortho and see the -- indirectly how it's shown that, but it wouldn't be something studied because of what -- that specific topic because we know that normothermia promotes so many other beneficial effects. And in fact you asked me for a study and you didn't -- and I don't have to even tell you what I mean by "a study," so I know that published literature is considered studies by many people, so that consensus statement by -- by Parvizi would count, so would the CDC recommendation to reduce



infections -- periprosthetic infections by maintaining normothermia, that would count. And for all the benefits of normothermia, I don't like a -- an answer that would be taken out of context, so I will maintain that answer.
Q. Do you have an understanding of whether or not using forced-air warming has an effect on hypothermia during the first hour of surgery?
A. I can't give you every detail of it. I would expect that FAW can help --
I'm trying to think of different studies that looked at timing of forced-air warming. But again, that's not what I was called to be the expert. There are other experts on the device.
Q. And -- and I agree to that. And you --
So you would agree that you are not an expert with respect to maintaining normothermia and its effect on -- all its effects on surgical outcomes.
A. There are articles I've written that show that the FAW was very eff -- extremely effective at maintaining normothermia. There are a number of published reports; they are part of that exhibit that's in there. And it's been recommended by association of the nurses. A lot has been written about it. So -- and -- and there are a number of



review articles that go through the literature, like Jacofsky's article -- J-a-c-o-f-s-k-y. So to that extent I'm -- I can give you an answer. To the extent of knowing the minute-to-minute effects of FAW, I -- that's not -- you have other experts to -- to handle that.
Q. Have you read Al Van Duren's deposition?
A. Whose?
Q. Al Van Duren.
A. Why is that not ringing a -- a bell?
Q. So I take it since it's not on your list of exhibits --
A. Who is he?
Q. Doesn't matter who he is. Have you read his deposition?
A. Unless some -- sometimes I don't know --
Can you spell the name, sir?
Q. Let me ask you this: If it's listed -- would it be listed --
If you read his deposition, would it be listed on your invoices?
A. Yes.
Q. Okay. So if it's not listed on your invoice, could we assume you didn't read his deposition?



A. No, I wouldn't read a deposition that didn't get --
Q. Okay. Have you read the deposition of Andrea Kurz?
A. No, I have not.
Q. Do you know who Andrea Kurz is?
A. Yes.
Q. She's actually a physician at the Cleveland Clinic; correct?
A. Correct.
Q. Okay. Have you read any of the depositions of Dr. Sessler?
A. I already said that earlier.
Q. Okay.
A. No.
I'll be happy, if you want me to read these at a later time, I'll be happy to do that --
Q. Well --
A. -- if you need that.
Q. -- it's not my job to tell you what to rely upon or the materials to give.
A. Okay.
Q. That would have been your -- the people you work for.
A. Okay.

Q. Turning to page five of your deposition dealing with the paragraph that starts "The impact of ventilation" --

MR. GOSS: His report?

MR. ASSAAD: I'm sorry. Correct, your report, Exhibit 5. Page five Exhibit 5. Thank you, Corey.

Q. You don't hold yourself out as a ventilation expert; correct?

A. I am not a ventilation expert. I know of ventilation to some extent, but --

Q. Okay. You wouldn't know how an operating room ventilation works and maintains positive pressure and the types of filtration used.

A. I would know that --

For example, at this consensus conference I was asked questions about the -- the success rate of laminar flow versus ultraviolet versus turbulent versus -- what was the other one -- versus something else. I had to actually give a few statements, so --

Q. Did you say ultraviolet? You meant ultra -- ultraclean?

A. UV radiation.

Q. Okay.

A. Okay. So I had to prepare little statements



on the literature at the time. Now that doesn't make me an expert, it just makes me looking at results of like New Zealand Registry about laminar flow and cup -- and I also had to look up space suits, so -- which were related, combination of laminar flow with space suits and the risk of periprosthetic infection for -- I did a little bit of that work for the consensus conference.

Q. Do you know what a Reynolds number is?

A. A what?

Q. A Reynolds number.

A. I've heard of a Reynolds number, but no, I'm not --

Q. Do you know what the Navier-Stokes equations are?

A. No, I don't.

Q. Do you know -- do you know what the Archimedes number is?

A. I know who Archimedes is, but I don't know what the Archimedes --

Q. Do you know --

A. -- number is.

Q. Do you know the difference between a lam -- what the Reynolds number would indicate, to know the difference between what's a laminar flow and a



turbulent flow?

A. These are the parts that I'm not an expert on, and that's why you see that certain -- certain --

I don't spend that much time on that part. That's not -- I'm not --

On the part of what you're asking me is infection rates with laminar flow versus turbulent flow, but not knowing how many cycles of -- of -- are -- are -- of air are coming per minute or at a certain point, what is disrupting the -- the turbulent flow or the laminar flow, what -- what's the effect of people going into the flow rate and things like that, that is not my expertise, which is I -- what I think you're asking.

Q. So sitting here today, would you agree with me that you don't have the expertise to indicate if any medical device that blows air, its effect on the airflow in an operating room?

MR. C. GORDON: Object to the form of the question, misstates his testimony.

A. I think I have been aware when something is blowing air in my face in the OR or things like that on a gross level, and on -- and on a micro level or a --

I have read these articles that are



pertinent to the case. I have my own opinions about what I think is relevant. I also have some opinions on certain conclusions that were made about different devices that are pertinent to this case.

(Witness's cellphone dings.)

Q. So tell me what a large eddy is with respect to flow.

THE WITNESS: Excuse me one second.

A. Say this again.

Q. Do you know -- do you know what a large eddy is with respect to turbulent flow?

A. I mean I know what an eddy is. It's a current that gets raised up.

No. You're asking me questions, and those are details of that that I would -- would not profess to be an expert on.

Q. Okay. Let's go to page nine under "Many things in the operating room impact airflow." What evidence are you relying upon that -- scientific evidence that surgeon traffic disrupts or impacts airflow in the room?

A. There -- there have been a number of papers and reports that have been written on the amount of surgeon traffic that affects infection rates. I think -- I could be wrong -- I think it's the Lidwell

study -- L-i-d-w-e-l-l -- but I could be wrong on that, where in a -- in a general surgery operating room where the -- there was an average of 18 people per OR case versus a group of cases where there is an average of four, the infection the rate was four-fold.

You're asking me about currents. Some of those articles, like that article, liken it to creating more currents, more doors opening and shutting, and that's --

Q. Well I'm familiar --

A. -- a direct answer.

Q. -- with the article, and wouldn't you agree with me that that article dealt more with the bioburden that's created by having more people in the operating room as compared to disrupting airflow?

MR. C. GORDON: Object to the form of the question, also lack of foundation.

A. Well you --

We could argue about that and say that's -- that's similar; more people in the OR creates more air currents from the people walking in and out of the OR, things like that. In our ORs we view that opening and we -- when -- cases in Baltimore, when there were problems, they slammed the door shut and said, "We don't want any flow of air." That was what our I.D.



people said. "We don't want the door opened or shut. We want no air currents from opening or shutting the door, and we don't want people walking around and throwing more currents." And that was stated by our -- our infectious disease experts --

Q. So --

A. -- in those periods of time when we wanted to reduce infections.

Q. So you're relying on what the infection disease experts told you in Baltimore in your opinion.

A. That, and reading articles, --

Q. What --

A. -- speaking to people, expert -- expert, and I think there's also some of -- some statements by the CDC. As well as this consensus statement mentions that, reducing that.

Q. But you have no education with respect to --

You're not an engineer; correct?

A. I already answered that question. I am not an engineer.

Q. Okay. And you -- and you have not done any --

You have no education with respect to how objects that move affect airflow; correct?

A. What do you mean I have no education?



Q. Well what --

A. Formal education? Scientific? I didn't write a --

Q. Do you take -- do you take --

Did you ever take a class on fluid dynamics?

A. No, I did not.

Q. Did you ever have a class on heat transfer?

A. No.

Q. Okay. I mean air -- air -- the -- you have --

You have no expertise to indicate whether or not someone moving in the operating room will affect the unidirectional or downward airflow of a ventilation system; do you, sir?

A. I -- I can read an article and see --

When the article that says a person moving into the room, their head moving this way or that affects laminar flow and causes laminar flow currents to become disrupted or can affect that, I'm -- I may not have an engineering degree, but I'm able to read certain articles, discuss different things with different people and, in my idea, form an opinion. That doesn't mean I have to know Reynolds numbers or be an engineer to be able to form an opinion.

Anyone, even if you are an engineer, these



are opinions, but I think that some of this makes sense.

Q. So --

A. It's a logic thing. Some of these things you do want to have an engineering degree to understand and calibrate ORs the correct way, I agree with you on that, but some of them --

Clearly, if you have people running around the OR and creating -- and waving their hands, that's not optimal for surgery.

That would be an exaggeration.

Q. What's the velocity of air that's created by waving your hand?

A. I can't give you an exact number right this moment.

Q. So my understanding is if I read an orthopedic article, that makes me an expert in that area of orthopedics --

MR. C. GORDON: Object to the form of the question.

Q. -- by just reading the article?

MR. C. GORDON: Object to the form of the question.

A. I never said that.

MR. C. GORDON: Also lack of foundation.

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Q. Huh?
A. I never said that.
Q. Well, you're relying on articles you've read, correct, even though they're outside your expertise?
A. I'm -- I'm allowed to have an opinion about many topics that are outside my expertise. As an orthopedic surgeon, as I said earlier, I can't divorce -- even though I'm not an infectious disease expert or microbiologist, I can't divorce myself from knowledge in taking care of the patients that have infections and working with the microbiologists, infections from the surgeons' points of view, and it -- you work as teams, but it is important for me to have a working knowledge of a lot more topics than are in my exact field of expertise past just general orthopedics or joint -- joint reconstruction about orthopedics. That would be my answer.
Q. Okay. On number eight you type -- you -- you say, "Many pieces of equipment in the OR generate air currents, including those that have cooling fans."
What devices are you referring to?
MR. C. GORDON: Where is that?
MR. ASSAAD: Number eight.
MR. C. GORDON: Oh.

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A. There -- there's a device where -- that irrigates wounds. We have a flow tube that goes into the wound that has a cooling fan on it.
Q. Is the cooling fan directed onto the surgical site?
A. No.
Q. Okay.
A. No. It's away from. But it has --
Q. And what's the CFM of that cooling fan, do you know?
A. I wouldn't know that.
Q. Okay. What other device?
A. I mean I can find any of these things out for you, but that's not to me relevant to knowing that. Maybe you find it was.
Q. Okay. What other device, sir?
Monitors?
A. Well those are further -- I'm not going to even think about those. But further away from the field are anesthesia machines, at least one or two, and they're going to have cooling fans that would be -- you'd want to maintain the temperature.
Q. Any evidence that indicates that the cooling fans of an anesthesia machine has caused a surgical-site infection or periprosthetic joint

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infection?
A. Not to my knowledge.
Q. Okay. What else, sir?
A. Irrigation device, cautery.
I don't know if the electrocautery machine has something in it that has -- it's a piece of machinery, it can't get overheated. I --
Has some mechanism for maintaining cooling in the machine itself because it's plugged in. I don't --
Q. Are you speculating or --
A. I don't know if it's a fan or not.
Q. -- you -- or are you -- are you --
Do you say that to a reasonable degree of probability, that you are certain that the electrocautery device has some sort of cooling mechanism?
A. I'm speculating --
Q. Okay.
A. -- there, but I would believe that's the case.
Q. Well let's not speculate. And I think counsel will agree with me that you're not here to guess or speculate. If you don't know the answer --
A. All right. I'll -- I'm going to think about

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the answer there.
Q. Okay.
A. Okay? And as we're sitting here, if we have a little break I might think about what has that.
Q. Okay. Any other -- any other devices that generate air currents -- air currents that you're aware of sitting here today?
A. Well when you're using a saw and you're actually sawing, you're creating air currents, so indirectly the saw is creating currents as you're using it.
Q. Any -- any scientific evidence that indicates that when you use a saw, the air currents that it creates causes any periprosthetic joint infection?
A. The whole -- yes. The whole --
Q. What's -- what's a citation I could look up?
A. Well if --
There's one citation that talks about home -- bringing your homemade drills and saws into the OR are not very sterile. That in itself is not a good idea, which people were doing in some foreign countries.
Q. Sir, I'm talking about what most people do in the United States of America. They don't bring in

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a --
You don't bring in a home saw into the surgical site; do you?
A. There -- there is --
MR. C. GORDON: Gabe, you have got to let him finish his answer.
THE WITNESS: I haven't finished my answer.
MR. ASSAAD: Corey, we are going to the court on this. He is not answering the questions and -- and --
THE WITNESS: I didn't even finish my --
MR. ASSAAD: -- we're not talking about what's happening --
MR. C. GORDON: Okay.
MR. ASSAD: -- in some Third World country about people bringing in drills and saws --
THE WITNESS: But you interrupted me before my answer was done.
MR. ASSAAD: Let me -- let me finish, sir.
We're not talking about --
You know, we're talking about what happens here in the United States of America, and he understands the question and he's just trying to delay.
Answer my question.

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THE WITNESS: I'm not -- not trying to delay.
Q. Name a site that indicates that a surgical saw used in an orthopedic surgery causes air currents that -- that cause periprosthetic joint infections. "Yes" or "no."
A. So --
MR. C. GORDON: No, no. Gabe, you're not going to tell him "yes" or "no" and you're not going to interrupt him --
MR. ASSAAD: Are you instructing him not to answer?
MR. C. GORDON: No, I'm going to -- I'm just --
I'm instructing you to -- to behave yourself.
MR. ASSAAD: I am behav --
I just want a -- I just want a cite. If he has a cite, great. If he doesn't or he says, "I'm not sure of the name of it," that's fine. If it's Exhibit A, he could point to Exhibit A. But I'm only asking -- the only thing I'm asking for, Corey, is a cite. I'm not asking for an explanation. A cite.
MR. C. GORDON: Gabe, I understand that tensions are pretty high on your side of the table and

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I'm trying to give you some latitude --
MR. ASSAAD: Okay.
MR. C. GORDON: -- so we can get through this deposition. Please calm down. Let him finish his answers. If you don't like them, move to strike, do a followup. But stop the interrupting, stop the cutting him off and stop the badgering.
MR. ASSAAD: I'm not badgering. I just want a cite.
MR. C. GORDON: Yeah, you are.
MR. ASSAAD: I just want a cite.
A. All right. So -- so number one, I'm not -- I don't feel tense here and I'm not trying to delay anything, but I'm -- I -- I prefer not to answer questions that I have never had before in some ways I think that are out of context. Saws --
The combination of using saws with the technique of the surgeon using the blades spews -- spews bone chips, particles, blood all over the place. The move -- it --
You're doing movements. You have to contain it. There's differences in technique. And in my opinion that is a major source of splattering of materials all around the case that could lead to contamination and infection of the cases. It is one

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of the major reasons why some people really do like having hoods so that when they use the saws, it splatters and it doesn't -- some of it con -- is contained and doesn't hit back into the patient. In terms of -- it --
It's just another one of those things where the saw has to be given back and forth by the nurse to the surgeon, back to the nurse and back. It's creating -- all the things we do in the OR -- OR are creating waves that are pushing air across.
I do believe that -- but I don't have it offhand -- that -- that there have been studies looking at different saws related to contamination in the OR and different techniques and different blades. I don't have those off my hand because to me that -- what I'm saying all makes sense to a surgeon.
Q. Okay. So let's go to number one. You agree with me that on item number one, "Surgeon traffic," there's no citation listed after number one; correct?
There's no citation in Exhibit 5 under number one of page nine, there's no citation listed, correct, to any cite?
A. What's the question? Right there on the page --
Q. Yes.

A. -- or in -- in the rest of all the references that we've done?
Q. I'm -- I'm not talking about Exhibit A.
On number one, you agree with me under "Surgeon traffic," there's no citation listed on -- after number one; correct?
A. Out of all due respect, the only way I can really answer is to look at that whole reference list and see if anything relates to surgeon traffic. And an answer, that's not true because the Parvizi thing there does mention surgeon traffic, so that's incorrect.
Q. What Parvizi thing? I'm talking about --
I mean are you looking at the same page I am, on page nine?
A. I'm looking at this.
Q. Okay.
A. And my whole report cites data. I don't put a reference on every line here. I put a number of statements, and a lot of these statements are backed up with what's in the supplemental list of references, which is why I did it, because I was told put a whole group of references that you've been relying on in here that will support a lot of your statements that you placed here. So for number one, I'd have to go



through this whole thing. It's definitely mentioned under Parvizi about operating traffic. Some of these other papers I'm looking at also mention operating room traffic. So I don't -- I don't really think --
I think that's an appropriate way to answer this.
Q. Okay. Well answer my question. Do you agree with me that on Exhibit 5 of your report under number one, "Surgeon traffic," and its effect on -- on airflow, there's no reference there; correct?
MR. C. GORDON: Objection, asked and answered.
Q. Correct?
A. I already answered the question.
Q. You have not answered the question, sir. "Yes" or "no."
A. The references --
MR. C. GORDON: Objection, asked and answered. Move to strike counsel's comments.
A. The references are contained in my list of references.
Q. Okay. So are you saying that all your references listed in Exhibit A are authoritative and reliable?
A. I never said that either.



Q. Okay. So sitting here today, if I want to know what you're referring to under "Surgeon traffic" --
(Witness's cellphone rings.)
THE REPORTER: Let's go off the record.
THE WITNESS: No. I'm okay. I'm not answering that.
THE REPORTER: Back on the record, please. We're on the record.
Q. If I want to know what -- for --
For anything that does not have a reference in your report, is it your testimony that it's all supported in articles in Exhibit A, which are -- which is Exhibit 8 to this deposition?
A. I --
In this case it was supported, but I agree with you that not everything I stated here was supported. As I said earlier, some of my statements I feel are common sense, they're statements that any orthopedic resident or surgeon would know, so I didn't support it. But any of my statements, if you want me to try to substantiate, I can look back and, after this deposition, try to substantiate any sentences like that that you have. I'd be happy to do that. I didn't --



Okay.
Q. Do you have an opinion -- strike that. What is the -- the --
With respect to all people in the operating room, which is pretty much items one through five, do you know what volumetric flow is created when a person walks?
A. No.
Q. Okay.
A. I can --
Happy to look that up for you if you really want me to know that.
Q. Do you know whether or not that volumetric flow would have an effect on the ventilation airflow over the surgical site?
A. I would --
Based on what I've read and what I would think, it could have an effect.
Q. Okay. How much -- how much airflow, volumetric airflow would be required to disrupt the unidirectional airflow in an operating room over the surgical site?
A. Of which type of ventilation?
Q. A unidirectional airflow coming down at about --

A. Turbulent airflow or laminar or -- or what -- what --
I mean they're all different. Some of them are horizontal laminar, some of them are vertical laminar.
Q. Unidirectional vertical laminar -- or unidirectional flow. Well strike that.
Do you believe that there are any operating rooms that have laminar flow?
A. Do I believe what?
Q. Is there any operating room that actually has laminar flow?
A. I don't know what your question is, but there are -- there are many operating rooms that feel they use laminar flow, yes.
Q. All right. What about in the United States?
A. Yes.
Q. Do you use laminar flow?
A. No.
Q. Do you use unidirectional flow?
A. I don't know your def -- definition of it.
Q. Okay.
A. We don't call it that.
Q. Okay. Well for downward unidirectional flow, turbulent if you want to define it, do you know



what volumetric flow is required --
(Mr. C. Gordon sneezes.)
Q. -- to disrupt --
THE WITNESS: Gesundheit.
Q. -- to disrupt the protective effect of the unidirectional airflow in an operating room?
A. No.
Q. Okay. Would number seven, "Moving of lights and other equipment directly creates waves or currents by individual (surgeon or team), as well as the specific object moving," do you know what volumetric airflow is created when you move lights?
A. No.
Q. Okay.
A. I'd be happy to find out if you really think that's important.
Q. Do you know how --
Do you know what the volumetric flow rate coming out of a Bair Hugger?
A. I don't want to say the wrong number, so the answer is no.
Q. Okay. Do you know what -- how much heat is produced by a Bair Hugger?
A. I have numbers in my head of what was said in articles.



Q. Okay. What's the number?
A. Some number like 800 milliwatts.
Q. Eight hundred milliwatts?
A. Milli, but the unit may be wrong.
Q. Okay.
A. But I know that in relation to what is generated in a ratio per -- per person on the operating room team.
Q. How -- how many milliwatts does a person create?
A. On the same ratio, if the number without the units is 800, then a person is a -- is a bit over 200.
Q. Okay.
A. And these -- okay.
Q. And have you actually looked at the operating manual or the -- of a Bair Hugger?
A. At some point, yes, but not very -- not in any specifics that I would comment on.
Q. I mean it's not listed on any of the stuff you considered; correct?
A. No.
Q. Correct?
A. That's not my field. That's not my -- as you would say, that's not my area of expertise. And other people can comment on that.



Q. Okay. Do you believe --
Do you have any opinion of whether or not heat can affect airflow in an operating room?
A. I have an opinion.
Q. What's your opinion?
A. It can affect.
Q. Okay. By the way, do you understand what plaintiffs' theory of the case is with respect to how the Bair Hugger increases the risk of surgical -- of a periprosthetic joint infection?
MR. C. GORDON: Well the way it's phrased, I'll object. You can ask him what he knows of -- what -- what his understanding of it is.
MR. ASSAAD: Okay.
A. I --
MR. C. GORDON: Do you understand why? Yeah.
A. You may have a different --
I know what some people have said or different -- there are many different things that have been said on it, articles, websites, maybe you, you, what's been said.
Q. You read the report of John Abraham; correct?
A. Very briefly, if -- if --

Q. It says here 15 minutes on Exhibit 7.
A. Yeah. I looked at it, but I don't --
Q. Have you read the report of Dr. Elghabashi?
A. Yes.
Q. Would you agree with me that Dr. Elghabashi is an expert in computational fluid dynamics?
MR. C. GORDON: Objection, foundation.
A. I can't assess what his level of expertise --
Are you talking about considered a legal expert or an expert in the whole field, what his --
Q. Expert in --
A. -- peers think?
Q. Expert in the field.
A. I don't know. I don't know.
Q. Is there a --
A. That's not my say to say who is an expert or not.
Q. Is there a distinction between a legal expert and an expert in his field?
A. I think there is a distinction between --
For example, some people might call an orthopedic surgeon that has an expertise in periprosthetic infections or osteonecrosis an expert in that field, but a board --



I believe, legal definition, any -- if you're in a legal case, any board certified pract -- you'd have to be --
A practicing orthopedic surgeon could be considered a legal expert to opine opinions in the case, and that's a different definition of the first part of what I said was an expert on specific topics, if that's what you're asking me.
Q. So -- okay.
Turning to page 10, you indicate on -- under the -- you have the bold that says "There are many sources...," but the first line after that says, "For example, 4 people involved in the operating room, as well as being much closer to the operative site than a Forced Air Warmer, generate much more heat than the Forced Air Warmer..."
Is that something that you agree with?
A. Well that's -- that's why I --
Those numbers I gave you was the best of my knowledge about heat generation when we -- we -- I --
Earlier, that four-questions-ago or so number about the ratios, I don't know the units exactly, but this 200 times four, a little bit more than 200 times four is more than the 800, with the 200 times four a lot closer than the 800, which is further



removed from the operative site. Eight hundred and fifty or 900 is more than the 800 from a Bair Hugger, which is further away, and that heat gets dissipated.
Q. But you're not certain about the numbers of 200 or 250; are you? For --
A. No. I've seen those numbers printed, I just don't know the -- what I don't know is the --
And again, I'm only as good as what I've seen printed in an article, and I'm not an absolute expert in this, but I see it in more than one place. And I don't know the units.
Q. So you were citing off numbers that you looked -- you've seen in articles; correct?
A. Yes.
Q. You've never done any studies or -- or calculated how much heat's coming off --
A. I definitely have not --
Q. Okay.
A. -- done any studies.
Q. Okay. I'm trying to let you finish my -- your answer. You got to let me finish my question.
A. I'm -- I'm sorry. I apologize.
Q. What --
You also go under "...there are many more heat sources closer to the field." What other heat



sources are there?
A. Well the --
For example, when the cautery is turned on, the machine that actually has the cautery that we are not sure whether it has a fan or not that -- that gets plugged into the wall, that -- that drives the machine --
Q. Are you talking about the electrocautery --
A. Yes.
Q. -- device itself produces heat?
A. Both. Both. The device when it's turned on creates like -- like 400 to 600 degrees of temperature.
Q. The control --
A. In fact, when you touch the tissue, it starts smoking up and you get -- you have to often get a sucker to get rid of the smoke. And if you touch it, it's going to be pretty damned hot I would say.
Q. And that heat is being generated above the operating room table, correct, when you use the device?
A. Directly in the wound of the patient.
Q. But it's not -- it's not heat generated underneath the operating room table; correct?
A. It's not -- it's not underneath the

operating room table.
Q. Okay. So the heat that it generates is above the -- the operating room table; correct?
A. Well yes. It's -- it's -- it's at the -- it's at the operating room table or --
It's in the patient's wound, so it's, yes, slightly above the operating room table. Yes.
Q. Okay.
A. Okay. Sorry.
Q. And the electrical box that controls the electrocautery device, do you know how much heat that produces?
A. I can't tell you that right now.
Q. Okay. Now you also mentioned saw blades produce heat; correct?
A. Well when you're hitting the bone and you're doing the case, again the -- the -- the bone is going to smoke up as you're cutting the bone. These are -- these are --
Hip or knee replacements generate a tremendous amount of heat. You're cutting them and you're going through them.
Q. Do you know how much heat that produces?
A. I can't give you a -- the amount. You can't even touch the blade after using it because you'll



burn your finger.
Q. And you agree with me that the heat that is being produced by the saw blade is above the operating room table.
A. It's above --
It's in the patient's wound, so anything in the patient's wound is above the table.
Q. Okay. And do you know how much heat the batteries that power the saw blades create?
A. I don't know the exact number. We --
Q. And you -- you --
A. We can get that, but there is certainly heat.
Q. And you --
A. The whole -- the whole --
Not only the battery and the saw blade, but the whole instrument can get, as you're using it more time and it's turned on, the whole thing can get really hot.
Q. And that -- that heat is generated above the operating room table; correct?
A. Correct.
Q. Okay. And the battery pack that -- that -- that use the space -- that are on the spacesuits, they're right behind the head of the -- the surgeons,



the people that use them; correct?
A. They're behind the head, or they can be hanging down on the shoulder --
Q. Okay.
A. -- across the lower black.
Q. But they're also above the operating room table; correct?
A. Yes.
Q. Okay. Do you know how much heat they produce?
A. No.
Q. Okay. The general overhead lights in an operating room, you agree that the heat they -- they produce is above the operating room table; correct?
A. Yes.
Q. Do you know how much heat they produce?
A. Often a watt, but I can't tell you how much.
Q. Okay. The focused overhead lights directly at field, those are above the operating room table; correct?
A. Yes.
Q. And the heat they produce is above the operating room table; correct?
A. Yes.
Q. And do you know how much heat they produce?



A. No.
Q. Okay. The ancillary hooded lights that many surgeons wear and the light generating unit, that's -- that's -- that's above the operating room table; correct?
A. Yes.
Q. Do you know how much heat they produce?
A. No.
Q. Okay. Do you know how much heat a patient produces?
A. I should know and I did know at one point, but I don't know exactly.
Q. Okay.
A. I'm -- I'm sure that's variable depending on the -- the patient.
Q. And you told me before with respect to the surgeons and the people that are moving around, that's roughly about 200?
A. To the best of my knowledge.
Q. Okay.
A. I will --
Q. All right.
A. I will recheck that.
Q. The machine to process fluid -- irrigation fluids, vacuum canisters and more substantial

canisters used nowadays that generate much heat, do you know how much heat they produce?
A. I don't know the exact number.
Q. Okay. Do you know whether or not they produce heat underneath the operating room table?
A. Well they are on the floor, so if you want to say under or pretty close to the bottom of the operating --
They start from the floor, they're -- they're sitting on the floor and they go upwards, so they're -- so that would be the closest of all these answers to being on the floor or below the operating room table, those -- that.
Q. Well you -- you -- you mentioned that you read -- on your invoice you saw the report of --
Did you receive a copy of -- oh, here it is -- Settles paper? You read the Settles paper; correct?
A. Very briefly I did.
Q. Fifteen minutes; right?
A. Yes.
Q. Were you aware that he measured that the temperature increased underneath the operating room table when the Bair Hugger was used?
A. I'd have to look at this report with you. I



wasn't -- I don't remember being -- I don't --
Q. By the way, when did you get the expert reports of Settles, Abraham, Lampotang, Hughes, Holford, the defense experts?
A. You want the exact date?
Q. Was it -- was it this month?
A. No. It was in June.
Q. Okay.
A. Somewhere like June 10th. So I -- I read these about a month ago, that's why I can't give you an exact answer.
Q. Number nine --
A. On the Settles paper, which I had read, 15 minutes was carefully enough for me to read that paper.
Q. By the way, do you feel any air come out of the Bair Hugger when you use it?
A. No.
Q. What about the --
A. Oh. Do I feel it when I'm in the case or --
Q. Yes.
A. -- do I feel it right there?
Q. When you're in the operating room.
A. No.
Q. Do you see air coming out of the neck, like



flapping around from the neck with a plastic sheet cover?
A. Not really.
Q. Okay. Have you noticed a change -- change in temperature when the Bair Hugger is on?
A. No.
Q. Now number nine says, "Often other power sources for special blades used in some surgeries (more often revisions) for burring bone, cement, et cetera - Anspach/Midas Rex devices generates a tremendous amount of heat."
Do you agree with me the heat that these devices produce are above the operating room table; correct?
A. Yes. Some of the -- some of these are plugged into a wall that could be like, say, on the -- there could be a wall outlet. So, for example, the Anspach device is plugged into a wall, but I don't think that's generating that much heat. It could be creating currents --
Q. Well the ones --
A. -- as it's moved around.
Q. Well the ones that generate a tremendous amount of heat, those are above the operating room table; correct?



A. Well an Anspach device --
I would say yes, that's correct.
Q. Okay. And sitting here today, you don't know the exact amount of heat that they produce; correct?
A. Correct.
Q. Okay. Standard elect -- electrocautery devices, those produce heat above the operating room table; correct?
A. Correct.
Q. And sitting here today, you don't know what -- the amount of heat that they produce; correct?
A. I know how many degrees that a -- in a general sense that an electrocautery hits when it's turned on. It's like between three and five hundred degrees Fahrenheit. It's pretty --
Q. But when you're asked about watts or BTUs --
A. No, I don't -- I don't know that.
Q. Okay. And you don't know whether or not that quick burst of heat affects the unidirectional flow in an operating room; do you?
A. No.
Q. Okay.
A. I'll defer that.
Q. And -- and in fact you don't know --

I mean based on your education, training and experience, you haven't studied the effects of heat on unidirectional flow in an operating room; have you?
A. The effects of heat on unidirectional flow. No.
Q. Okay. Number 11, "Ancillary cautery devices - Plasmablade, Aquamantis, Canady, and others." You agree with me that all those devices produce heat above the operating room table; correct?
A. Correct.
Q. And sitting here today, you have no idea --
A. I'm going to say that I haven't studied that question about heat and everything like that, but I have read these articles and I see what -- the arguments that are made, so I -- I can still render certain opinions.
Q. Okay. And I can read orthopedic articles and render opinions as well in a court of law; correct?
A. Yes.
Q. Okay. Is that the standard --
MR. C. GORDON: Object to the form --
Q. -- that you're going by?
MR. C. GORDON: Object to the form of the question, --



A. No.
Q. Okay.
MR. C. GORDON: -- lack of foundation.
Q. Okay. Let's talk about --
So you agree with me that under 11, you don't know how much heat they produce; correct?
A. Can I say -- I --
In terms of what goes on in an operating room, I'm still the primary important person or the primary person in charge, that I have to theoretically be aware of not only my discipline but the anesthesiologist, except certain things, but be aware and understand other things. So I don't have to be the absolute expert on every single topic, but I still can have an opinion about them and I -- and I think that's very appropriate.
MR. ASSAAD: Move to strike as non-responsive to a non-existent question.
Q. Number 11, you agree with me that the devices under number 11 on page 11 of Exhibit 5, you don't know how much heat those devices produce; correct?
A. I don't know exactly.
Q. Okay. Number 12, "Various ancillary devices in the operating room by anesthesiologist, example,



defibrillator, computer, their monitor, their anesthesia machine is a source of heat."
Sitting here today, you agree that none of those devices produce heat underneath the operating room table; correct?
A. I wouldn't know that --
Q. Okay.
A. -- one way or the other.
Q. And sitting here today, you don't know how much heat those devices produce; correct?
A. Correct.
Q. Okay. So don't you think it would be important to know the exact amount of heat being produced by these devices to offer an opinion as to whether or not they have an effect, if any, greater or less than the Bair Hugger device?
A. So my answer is once I knew that the four players that are involved in the surgery generate way more heat than -- directly to the patient than a Bair Hugger device, which is feet away, and that amount of heat would be dissi -- dissipated by the inverse of the distance, then to me all these other things were just further additive events and I didn't feel that I had to study and give you a -- a number for each of these answers. Nor do I feel that it -- it



necessarily matters whether it's below the table or above the table. I'm way more interested in heat that's generated right to the wound, which is the point of interest.
I certainly don't think that if I had spent a bunch more hours and been able to give you much better answers that would have been --
Well anyway, so that's why I felt that this was appropriate. These are the different devices that generate heat. I'd be happy to go and -- and read back these questions and give exact numbers and give a much better answer, but my basis of using that opinion was that I already knew that direct heat involvement and what a patient sees, which is what I'm worried about is what's happening in that wound, in that knee replacement or hip replacement, that is way more important in what's hitting that patient than things so far away. And that --
MR. ASSAAD: Move to strike as -- I'm sorry. Move to strike as non-responsive.
Q. What methodology -- well strike that.
Does the location of where the heat is produced, was that any part of your methodology in formulating your opinions?
A. I just told you it was. It even says it

here on page 10.
Q. I'm saying the location in the operating room where the heat is produced, where the device is, did you take that into account with respect to your methodology in formulating your opinions?
MR. C. GORDON: Objection, asked and answered.
A. It's --
I just gave you the answer.
Q. Are you not going to answer my -- not going to --
A. I just did.
Q. No.
A. It's on page 10. Yes.
Q. Page 10?
A. It's further away from the field. The forced-air warmer is further away and any heat would be dissipated.
Q. I understand --
A. I just said that.
Q. I understand further away from the surgical field. That's not my question, sir. My question is: The location of where the heat is generated, besides the distance away from the surgical field, did you take any -- did you take any other consideration of



where -- of the location of the heat?
A. I think you're trying to ask me whether -- whether it's on the floor or if it's a thing or if it's disrupting sort of waves. No. I'll --
Q. Okay.
A. I'll defer those opinions to other people.
Q. Okay. What is the velocity of the airflow underneath the drapes when the Bair Hugger is being used?
A. I don't know. We -- I don't know exactly. I -- I did know at one point. I don't want to guess here.
Q. Okay. So what is your basis that you say on page 10, "...any airflow that emerges from under the drapes is so low in velocity that it has no impact on the air currents in the OR?"
A. I guess the basis is -- is a -- is I can't --
I can feel so much air flowing from people moving around me and all that, and I can see the drapes moving from different things, but I don't feel anything from -- anything from a -- from a Bair Hugger device that's far away that affects any air currents that does anything to my operative field.
Q. But you don't know the airflow velocity



of -- coming out underneath the drape; correct?
A. I don't know the exact airflow velocity.
Q. Okay. And -- and what do you wear during an operation? Do you wear a hood?
A. No, I don't -- I don't use it. I have a -- a gown --
I have my regular surgical scrubs, I put on booties, on my pants, I have a -- a bouffant over my hair, I have a -- a mouthpiece that goes over my mouth and my nose that's strapped in, and when I go into the OR I am -- I'm -- we here -- and it's been a move towards paper gowns, so I -- I am paper-gowned, and then I double glove. And I believe -- I don't believe I missed anything.
Q. Anything over your eyes or anything?
A. Oh. Thank you. I did miss something. Yes. And we -- we would like to have protective eyeware, and I do forget that sometimes and then I'm reminded. I have two people that are supposed to remind me to always --
Everybody on the team should have protective eyeware. That's a new Cleveland Clinic dictum. So yes, we have these sort of clear-goggle type of things that are disposable that everybody wears. And that's a new rule, that you're not allowed to be in the OR



without those.
Q. What are you relying upon with respect to the -- to your understanding that the Bair Hugger filters are MERV 14?
A. There was a whole --
There were a bunch of articles. There was an AORN article about specs which is mentioned in the list of references that I have. There were -- there were a few of these articles that talked about that. I'm not --
I agree that I'm not an expert on those regulations and everything, but I did look at those articles and see what --
Q. So your basis --
You think that there's articles that indicate that the Bair Hugger filter is a MERV 14. Is that my understanding here today?
A. Yes.
Q. Okay. With respect to the -- the Cleveland Clinic abstract that's being presented next week at MSIS --
Would you agree with me that the Cleveland Clinic is a teaching hospital?
A. Among other things.
Q. Okay. And they -- they have fellows,

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correct, --
A. Yes.
Q. -- that come in and out? They -- they're there for -- I think it's five years -- or four years.
Is it a five-year residency for -- for orthopedic surgery?
A. No. Fellows are there --
Clinical fellows are there for a year.
Q. Yeah, but residency is five years.
A. The residency is five years. Some people opt for a sixth-year --
Q. Okay.
A. -- research year.
Q. So it's five-year residency and fellows; correct?
A. Yes.
Q. Okay.
A. It's really four years of orthopedics, one year of an internship where they do a little orthopedics. Some people opt to do an extra year. We do have clinical fellows as well.
Q. And you mentioned that there were, I think -- I think there were -- there were a large academic center and two high-volume arthroplasty regional hospitals, correct, part of this study?

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A. I didn't do the study, so I don't know what they --
What does it say?
Q. It says, "Patients who underwent primary TJA at a large academic center and two high-volume arthroplasty regional hospitals..."
A. Is that what it --
Can you give me the report again?
Q. Exhibit No. 11. I believe it's in here. It should be --
A. Here.
Q. Okay. Under "Methods."
A. Okay. So -- so this would have been main campus, and the two that were picked would have been Lutheran and where the joint replacements -- I'm not sure where the --
Lutheran would -- would be one of the two high volume, and I'm not sure which of the other two. It might have been -- it -- it would have either been -- hmm.
Q. Florida?
A. Oh, no. I don't think it used Florida.
Q. Well isn't W. -- Barsoum, W.K. in Florida?
A. Oh. So maybe it did. I don't think so, but maybe.

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Q. Do you know -- do you know Wael Barsoum?
A. Yes.
Q. How do you know him?
A. He's the -- he's in my department. He's an orthopedic surgeon and he's the -- he's also the head of Weston's Cleveland Clinic.
Q. Which is in Florida; correct?
A. Yes.
Q. Okay.
A. So he may --
That may have been part of the database. I don't know. We can --
I can get you the details of the study.
Q. Do you know -- do you know whether or not, with respect to -- with respect to the analysis, they took into account individual resident or surgeon infection rates when they compared the forced-air warming to the forced-air warming with a HEPA filter?
A. I can't tell you that.
Q. Okay. Because I -- I think you stated in your report that surgeons' experience has an effect on PJI rates; correct?
A. Yes.
Q. I mean if you look at page --
A. I agree with that. You don't have to look

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at the page.
Q. Well I --
Just for the record, if you look at page 18 of Exhibit 5, you say, "Variations in skill of surgeons or surgical techniques can markedly influence infection rates;" correct?
A. Correct.
Q. Okay. And if you also look at Exhibit No. 11, you agree with me that they looked --
They did a univariate analysis; correct?
A. Well I imagine they did a univariate analysis first. I don't know --
Q. And a multivariate analysis, correct, if you look at the second page?
A. Well what does -- what does it say? The first page says that --
Q. Well if you look at the second page, you have the table that says "Univariate Analysis" and "Multivariate Analysis." Okay?
A. Fair enough.
Q. And is it okay to do a univariate analysis here --
MR. C. GORDON: Object to the form of the question.
Q. -- in Exhibit No. 11?

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A. It's okay to do univariate anyway. How much credence it is, you --
You do a univariate analysis often first and then see if it's sometimes worth doing a multivariate analysis.
Q. Okay. So you wouldn't criticize a -- a paper that does a -- that first does a univariate analysis, correct, and then does a multivariate analysis?
A. I wouldn't criticize?
Q. Yeah.
A. Depends on the paper.
Q. Okay. Do you have any criticisms of this paper, Exhibit 11, this -- this --
A. I don't --
Q. -- abstract?
A. It's just an abstract right now. I don't --
Q. I understand. But on the abstract, do you have any criticisms?
A. I'm --
I think in a -- in a general sense it's a nice abstract. Abstracts are not meant to be papers. Every question that you're asking you can't get from an abstract. I think it -- so --
Q. Has it been accepted for publication?

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A. It's a presentation, and usually these presentations will go in to clinical orthopedics and related research X months afterwards. That's why the paper gets written afterwards.
Q. And A. K. Klika, that's -- that's Alise?
A. Alison.
Q. Alison.
Is she in the Cleveland Clinic here?
A. Yes.
Q. Is she a resident, a fellow, attending?
A. No, she's one of the --
I don't know her exact title. She's one research director. She's a permanent employee that oversees research.
Q. Okay. So she's not a physician?
A. She's not a physician.
Q. Okay. And she's the one that's presenting this, correct, at MSIS?
A. I don't know if she's presenting it or -- I would have --
My guess -- if you ask me to guess -- before you made that statement would have been that Carlos Higuera is a presenting it. He's a physician.
Q. Okay.
A. Actually, can I amend that answer? Excuse

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me. It --
Since Carlos Higuera probably has more than one of these presentations at the MSIS, it may be very possible that the very first author here, who is a guy named -- who is a research fellow, his name is Gannon Curtis, he would be the one that may be presenting. He would be the more likely. But I can certainly find that out.
Q. Looking at page nine --
Well let me ask you this: You've reviewed many studies in this case; correct?
A. Yes.
Q. Research papers; correct?
A. Yes.
Q. And you agree with me that if -- if you're going to make an opinion on a medical device, that you should read studies that pertain to that specific medical device; correct?
A. It's not a bad idea.
Q. Okay. Like, for example, if you want to know whether or not the Bair Hugger concerned like -- strike that.
If you want to know what the Bair Hugger 750, which is -- or 775, which is the latest Bair Hugger device, you want to look at studies on that

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device; correct?
MR. C. GORDON: Object to the form of the question.
A. I don't -- I don't really understand the question.
Q. Well you know that devices change over time. They -- they're either improved or some -- well strike that.
Do you know the difference between a -- a Bair Hugger 775 and a Bair Hugger 505?
A. I don't know all those differences.
Q. Okay.
A. I know -- I know that some of them have differences with different --
Q. I -- I don't want you to guess.
A. -- for upper extremity or lower extremity or straps, and there's like -- I've seen pictures of 20 different models. And the answer is no, I don't know those. And I just --
Q. I'm talking about the blowers. Forget about the blankets. Do you know the difference between a model 505 blower and a model 750 blower?
A. There was a difference in filtration efficiency, I don't know the exact numbers, and things like that.

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Q. Was there a difference in the heat output?
A. I don't know those numbers.
Q. Well do you think that when you look at a study you should know what device is being used to determine whether or not I could apply that study to the device that's at issue in this case?
MR. C. GORDON: Object to the form of the question.
A. Not necessarily.
Q. Okay. So --
A. If I -- if I think the device --
No, not necessarily. If I think the device is safe for both of them, I don't necessarily have to analyze what you're asking me to analyze.
Q. Looking at page nine under those -- those articles you cite at the top, which is Hall poster, Zink, Dirkes, Avidan, Tumia, Huang, Moretti, Occhipinti and Oguz, sitting here today do you know what devices that were -- that were being looked at in those studies?
A. Well you can surmise that there might be slightly different models in them because they were from different dates. So would I agree with you on that? Yes.
So you are also right that sometimes when

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you change different features of a device or a model, the change could be for the better, it could have no effect, or it could be for the worse. Okay? So I can't disagree with that. And these -- these are posters that -- or presentations -- most of them were actually published -- over a wide span of years, from 60 years with a model that's changing. But having said that, if I was trying to figure out, oh, this -- this device change might have led to this problem and this led to this problem, I didn't have any problems in any of these studies.
Q. You -- you didn't see a problem in the Huang study on the Bair Hugger?
A. No. No. I didn't see a problem in any of these studies.
Q. Or Moretti?
A. Moretti, that --
These are supporting of the Bair Hugger, these studies.
Q. So you think -- you think Moretti supports the Bair Hugger?
MR. C. GORDON: Objection, asked and answered.
A. Absolutely. Yes.
Q. You would bet your whole opinion on this

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case that Moretti supports the Bair Hugger.
MR. C. GORDON: Object to the form of the question.
A. I don't have to bet my whole opinion on this case.
Q. Well are you that confident that Moretti supports the Bair Hugger?
A. I don't know what --
I looked at the data. I don't know what the conclusion is. I'm pretty sure the Moretti study supports --
Q. Well are you --
A. -- with a high degree of probability, yes.
Q. Okay.
A. The same thing that you want from this case. I'm under oath.
Q. So the --
A. Is -- is it --
I will say this, because you told me to bet my whole opinions on this case -- that's pretty strange -- everything I'm giving you is to the best of my knowledge at this point. So yes, if you show me the study right here, maybe I mixed up a study, I don't think so, but I would --
And there are more than one Moretti study,

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to the best of my knowledge, also.
Q. Oh, there is?
A. I thought.
Q. Okay. So is it --
All the opinions you give in this case is to the best of your knowledge; is that -- is that your -- is that your -- is that what I just heard?
A. Yes.
Q. Okay.
A. I mean under oath, this is the best of my knowledge.
Q. Okay. Are you aware that Oguz showed that the Bair Hugger had an increase in bacterial load over the surgical site than the Hot Dog but not a statistically significant difference?
A. It was absolutely not statistically significant.
Q. But you agree --
A. That's what their conclusion was.
Q. But you agree with me that when you looked at the data, that there was an increased bacterial load over the surgical site with the Bair Hugger than compared to the Hot Dog.
A. It's not statistically different, so the answer is: That's not --

So the answer is: As a scientist, you couldn't say that.
Q. Well this --
A. No difference.
Q. -- is statistically significant, Exhibit 11, and you're going to go back and do some more investigation; correct?
MR. C. GORDON: Object to the form of the question.
Q. I mean there's something to be said --
A. Well if -- if I'm talking about --
In that study, all I have to do as far as --
I'm going to answer you on that study.
Q. Exhibit 11.
A. It's true --
I can also answer you on the Moretti study, --
Q. We're talking about Oguz.
A. -- not the Oguz study, because --
But you said -- acted like Moretti is not supporting Bair Hugger when it does. So let's go back --
You just went to Carlos Higuera's study.
Q. Yeah.
A. To -- to not show statistical difference



between these two devices, you might need not only five thousand, you might need fifty thousand, hundred, two hundred, if there really truly is a difference. So it is not necessarily powered to show a difference between those two devices.
But another way to look at this study is: Is this study sufficiently powered to show that the -- that the Bair Hugger does not increase infection rates versus the Mistral device? And in fact the Bair Hugger has a lower infection rate than the Mistral, and for the Bair Hugger to actually get to a point where it would be a statistically higher likelihood of causing infections than the Mistral, based on these numbers, it might be powered for that. It's not powered to show that the Bair Hugger is superior to the Mistral, but it's incre -- I think it's incredibly powered to show that the -- the Bair Hugger is not inferior to the Mistral because it's actually -- with all these big numbers, it's performing better than the Mistral.
Does that answer your question?
Q. Well that's fine. So if you look at the Oguz study where it shows that there is a difference in the bioburden when you compare the Bair Hugger to the Hot Dog, though it's not statistically



significant, that's because it only looked at 80 patients and it's underpowered; correct?
MR. C. GORDON: Object to the form of the question.
A. No.
Q. Okay.
A. Let's look at the study. I don't agree with you.
Q. All right. Now you agree with me that when you prep the patient in the operating room by putting on the drapes and -- and moving the patient, there's probably a high amount of bioburden during that time about the surgical site -- surgical table.
A. Some people say that's some of the most bioburden. I'm not so sure I agree with that, but some people say yes, that's the most right there.
Q. Okay. Before incision, before anything else, it's when you're moving -- people moving around, a lot of particles and bacteria are -- from not only the patient but also people setting up the patient; correct?
A. Yes.
Q. And these are other people --
Those are other colleagues in the field of orthopedic surgery that say that? You say other



people. Who -- who are the other people?
A. No. I'm saying the printed papers --
Q. Oh, okay.
A. -- that -- that mention that, that that may be a --
Q. Okay.
A. -- large source.
Q. Okay.
A. Like this concensus type of paper. Like Moretti's paper actually says -- Moretti's paper said that, that the -- and it was lower than the amount that was in preparing patients in terms of --
Q. Right. So -- so you think the consensus done by Parvizi or organized by Parvizi is authoritative.
A. I didn't say anything is necessarily -- I don't --
You'd have to define what's authoritative. It's a --
Q. Okay. I believe --
A. It's a pretty good thing that was put out by a series of -- of several hundred people about a peri-prosthetic infection --
Q. Well do you agree with -- I'm sorry.
A. Okay.

Q. I'm sorry. Are you done?
A. Well I'll be done.
Q. Do num --
Do you agree that the numbers of bacteria arriving at the surgical wound correlate directly with the probability of surgical-site infection?
MR. C. GORDON: Object to the form of the question.
Q. Do you agree with that statement?
A. The number of bacteria --
Q. Arriving in the surgical wound correlate directly with the probability of surgical-site infection.
MR. C. GORDON: Same objection.
A. It would depend on what you're talking about. So are you talking about two -- two versus one or -- or millions versus hundreds?
So the answer is: millions versus hundreds? The answer is yes. The answer is: three versus one? The answer is no.
Q. Well let me ask you this then.
A. What do you --
What are you asking?
Q. Question one in the consensus. "Do numbers of bacteria arriving in the surgical wound correlate



directly with the probability of surgical-site infection?"
Consensus answer: "We recognize the probability of SSI correlates directly with the quantity of bacteria that reach the wound. Accordingly, we support strategies to lower particulate and bacterial counts at surgical wounds."
Would you agree, disagree, or abstain?
A. Well I just told you if -- it's -- what my answer was. You do want to reduce bacteria. That's what we -- that's what we're trying to do.
Q. And lower --
A. But your question was different than mine.
Q. I'm reading directly from the concensus.
A. No, no. Now I --
Oh. With that answer, I agree with that.
Q. Okay. So -- so you would say --
A. Oh, oh, I definitely agree with that.
Q. Okay.
A. Not the first question, which was not phrased that way.
Q. And I'm reading directly from the concensus.
A. Yeah, of course.
Q. So you agree --
A. I agree with that.



Q. Sorry.
A. Sorry.
Q. So you agree that --
So you support strategies to lower particulate and bacterial counts in surgical wounds; correct?
A. Yes.
Q. Okay. And the reason why you want to lower particulates is because particulates carry bacteria; correct?
A. Some --
Q. Or can, can carry bacteria.
A. Some particulates --
Q. Okay.
A. -- can carry bacteria.
Q. And you -- you cited to ASHRAE. Do you agree with ASHRAE that between one million to nine hundred million squames are -- are disseminated during a two- to four-hour surgery?
A. I don't know the exact number, but it's a lot.
Q. Okay.
A. It is a tremendous amount. It's sometimes more than you would ever dream of.
Q. Okay.



A. So whatever you're saying, I don't -- you know, if you told me --
If your question was do you believe it's fifty to a hundred thousand or five hundred to a million, I mean that's fine. I don't --
Q. You wouldn't disagree with the studies that ASHRAE cites to.
A. Well I don't know who did the study. But, you know, I look at some of those studies and -- and there are eight studies and the -- and the variability, like that number you gave me, might be like orders of magnitude between each study. But I think I would agree with you it still says the same point: there's a lot of squames that are being shed.
Q. And --
A. So that's --
So I think we can agree on that.
Q. It depends on the number of people in the operating room.
A. How the study was done, what were they measuring, what was the technique, things --
There's so many different ways to measure particles and sizes and the squames and the -- this and -- what type of procedure. There's a lot of different answers to -- to that question, but I think

we agree on what you just said.
Q. You -- you cited to the Sessler study; correct? And you -- you looked at that; correct?
A. I looked at that at one point, sure.
Q. You realize that was funded by 3M; correct?
A. I didn't know who funded it.
Q. Okay. Well do you know if that study was performed by 3M?
MR. C. GORDON: Which Sessler study are you talking about?
MR. ASSAAD: The Sessler one with particle counts. I'm sorry.
Q. The 2011 Sessler/Olmstead study. Are you fam -- are you familiar with that study?
A. You'd have to show me it.
Q. Okay.
A. There's a few Sessler studies. I'm more familiar --
I mean the normothermia study is the one that I really -- that I think I cited.
Q. Are you aware that during the deposition of -- of Andrea Kurz, that she stated that currently there's so -- there's no scientific -- there's no current scientific evidence that maintaining normothermia reduces the risks of a surgical-site



infection?
A. Andrea Kurz --
MR. C. GORDON: I object to the form of the question, mischaract --
A. Andrea Kurz --
MR. C. GORDON: Hang on.
-- mischaracterizes the evidence.
A. Andrea Kurz is on -- on an opioid/narcotic reduction at Cleveland Clinic's subcommittee or committee with me and that's where I know the name. I think I met her, was introduced to her, but other than that I -- I don't -- I don't --
Q. Were you --
A. I don't know what -- I didn't --
As I said before a few times now, I've never read her deposition and know what she said.
Q. You're aware --
Were you aware that she -- she -- that I took her deposition in this case?
A. I may have been. Let's see, I -- I know you -- you took the Daniel -- the Sessler one because I told you about that conversation, and I think it was mentioned to me that you took a deposition for her, but it went past me because it's not something that I read. And it was mentioned five months ago, it wasn't



in my brain, so not -- not there.
Q. If you look at page four of Exhibit No. 3 --
A. Okay.
Q. Here you go.
A. I got it. I have it. Oh, the original.
Q. -- under number 15, it says "Does forced-air warming increase the risk of SSI?" Do you see that?
A. Yes.
Q. Okay. And this was the Sessler study; correct? Or no, this was --
I -- I don't know what study you're referring to.
A. Alijanipour. Nine, number nine? What -- what study --
Q. Fifteen. Fifteen.
A. Oh, I'm looking at number nine. I'm sorry.
Q. Page four --
A. This is a chapter in the annual review of --
Oh, page four.
Q. Yes.
A. I apologize. I keep --
Page four.
Q. I think it's a 15 there. It's nine -- number nine looks like a 15.
MR. C. GORDON: Can I point him to it



because I --
MR. ASSAAD: Yeah.
A. Well I see your fifteen.
Q. Okay. It says, "Does forced-air warming increase the risk of SSI?" And I don't know -- I don't know if you're referring to the article that's number nine, but underneath you say "Contrary Sessler - no decrease..." Do you see that?
A. It says "Contrary Sessler - no decrease in air quality laminar flow."
Q. Okay. Where are you -- where are you getting that information from?
A. This is from the --
I believe this is from the Parvizi consensus statement.
Q. Okay. And --
A. So this -- so that this is --
This Alijanipour paper that is published in Journal of Orthopedic Research, which you can see in 2014, has a supplemental issue. It says on very top it's from the MSIS meeting, so it's on a section that --
Q. From the consensus?
A. From the consensus. And it mentions some of the things that were mentioned in the consensus; I'm

not saying it's complete, but it mentions some of the topics. So on the number 15, you can read it yourself or you -- if -- you can have me read it.
Q. I don't need you to read it. My question is: Have you looked at -- have you actually looked at the Sessler article that shows particle counts in an operating room? Have you read it?
A. I don't know that this article was on the particle counts.
Q. Okay.
A. There was more than one Sessler article, and I read the one on normothermia earlier in his career --
Q. What about Memarzadeh?
A. -- that had the four --
Q. What about Memarzadeh? Two lines under Sessler, it says, "Memarzadeh - no negligible disruption" or --
A. I don't know if I read that or not.
Q. Okay.
A. So here, "Moretti - increased bacteria but lower than simply placing patient in the OR!" which they used as their -- as positive for favoring FAW.
Q. For Moretti?
A. Yeah.



Q. Okay. If you were to compare the bioburden --
(Witness texting on his cellphone.)
MR. ASSAAD: Am I interrupting you?
THE WITNESS: No.
MR. ASSAAD: Okay.
THE WITNESS: Sorry.
Q. Okay. If you were to compare the bioburden of -- created by a device being opposite the Bair Hugger, would you compare it to the bioburden when -- after the place -- the patient's been prepped and get that as a control, or check the bioburden when the patient is being prepped?
MR. C. GORDON: Object to the form of the question.
Q. Let me -- let me withdraw that question.
A. You could do it both ways.
Q. Okay. Well you agree --
You stated previously that -- that there's literature out there that the bioburden is the most significant during the time the patient is being prepped.
A. There is some literature. That doesn't mean I agree with it. And -- and it may also depend on how you prep. There are different ways to prep patients,



et cetera.
Q. But the prepping can have an effect on the bioburden over the surgical table; correct?
A. Yes.
Q. Okay. Depending on how you prep; correct?
A. Yes.
Q. You prep the patient and the patient is ready to go and the airflow is on and everything's going to settle out in the operating room and any type of bioburden that was increased is going to be removed by the ventilation system; correct?
MR. C. GORDON: Object to the form of the question.
A. Maybe.
Q. You're saying the bioburden is not going to decrease above the surgical-site table after the patient's been fully prepped and left at rest?
A. You hope. I mean there's still a bioburden that's always there. Is that what you're asking me?
Q. Is it going to decrease?
A. When the patient is prepped --
Q. After the patient's prepped.
A. We hope it's going to decrease.
Q. Well if you had an opinion today, what would your opinion be?



A. Yes, it's going to decrease.
Q. Okay.
A. With the one on the skin, yes, that bioburden is decreased.
Q. Because the patient is not moving around and there's less people around the operating room table.
A. Patient's enroute, you just put an antibacterial on the operating site, et cetera, and that's -- we -- for that operative site you're reducing the bioburden.
Q. And also the bioburden in the air around the patient, because there are less people moving around prepping the patient.
The patient's already been prepped; correct?
A. I will agree with that.
Q. Okay. So would you agree with me that if you're going to compare whether or not the Bair Hugger has a -- has an effect on the bioburden over a surgical site, that you should compare the bioburden after the patient's been prepped with the Bair Hugger off and then turning the Bair Hugger on afterwards?
MR. C. GORDON: Object to the form of the question.
A. It -- it's different questions that you're asking. I mean that is one way to do it.

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Q. Well you want to get a control that would be the actual bioburden that would occur during a surgery with the Bair Hugger off; correct?
MR. C. GORDON: Object to the form of the question.
Q. With -- with not other confounding factors such as prepping; correct?
A. Let me write it down. So in one study you have the Bair Hugger is on. Right? But you're prepping the patient and you're doing all that stuff.
Q. No.
A. That's what happens. You do realize that's the reality.
Q. You think the Bair Hugger gets turned on before --
A. It's very --
Q. -- before the Bair Hugger blanket's even placed?
A. No. It's while some of the prepping is going on the Bair Hugger has been turned on. It's not done.
Q. Okay. Before the drapes or after the drapes, the draping?
A. It -- before --
During the draping.

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Q. Okay.
A. During the draping.
Q. Okay.
A. So there is some simultaneous stuff going on. We don't just do things in series, which is what you're saying. We do some things in parallel.
Q. Let -- let me --
A. So -- so just --
Q. Let -- I know you --
A. I just want to write down what you're saying there.
Q. Well I want to write down so it's correctly so I don't have to go over this, because I --
A. Okay.
Q. -- I think I see what you're saying and -- and with that assumption, my question is simply this.
A. Okay.
Q. If you want to know if the Bair Hugger increases the bioburden during surgery when the patient has a wound, would you agree with me that you need to compare when the patient -- you need to compare with the Bair Hugger on as compared to the Bair Hugger off during the same time period of when the surgical wound exists?
A. You -- you want to --

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MR. C. GORDON: Object to the form of the question.
A. You want to compare it at -- yes, on/off at similar --
Q. Time.
A. -- time periods of the case.
Q. Yes.
A. I agree with that.
Q. Okay. I mean, for example, if the Bair Hugger is on and you're prepping the patient, there's many confounding factors such as people moving around, putting drapes on. That's going to affect the bioburden over the surgical site; correct?
A. But if your control is when it's off and those same factors are going on, you could do that study.
Q. Okay. So you have to --
But you want to keep the factors the same; correct?
A. No. I'm -- I just told you that you --
I hear what you're saying and I don't mind what you're saying, and you can do the study that way that you're describing to me, but you can always -- also do the study the other way, the Bair Hugger on at the same time that things are going. You still have

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the control group.
Q. Would proper --
A. But being prepped and all that stuff, it still represents the control group whether the Bair Hugger is on or off.
Q. But as long as the control group --
A. You might -- I mean your studies --
Q. Okay.
A. Yeah.
Q. But -- but you have to agree with me that as long as the control group, the only thing that changes is that the Bair Hugger is turned on or off, depending on what you consider the control group, you need that single change; correct? If you make any other changes, it's going to affect -- it may the affect the results.
MR. C. GORDON: Object to the form of the question.
A. I'd have to see what you're saying. But I --
In a general sense, yes.
Q. Okay.
A. You -- you --
When you do an experiment, you want to change only one variable; otherwise, they can affect

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the results. I a hundred percent agree with that.
MR. C. GORDON: Can we take a break sometime in the near future?
MR. ASSAAD: Sure. Let's take a break now.
THE REPORTER: Off the record, please.
(Recess taken.)
BY MR. ASSAAD:
Q. Dr. Mont, I'm going to read again from the consensus that you're familiar with.
Question number two, page 115 of the consensus. "Do numbers of bacteria in the operating room (OR) environment correlate directly with the probability of SSI?"
Consensus: "We recognize that airborne particulate bacteria are a major source of contamination in the OR environment and the bacteria shed by personnel are the predominant source of these particles. The focus in our recommendation is to reduce the volume of bacteria in the OR with particular attention to airborne particles."
Do you agree, disagree, or would you abstain?
A. I would --
I'd want more discussion, so I might abstain.

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Q. Okay. Are you -- are you aware that 93 percent agree with that statement?
A. That's fine.
Q. Okay. And only five percent disagree.
A. I don't think it's terribly bad. I think that's fine.
Q. But you agree the 93 percent agreement according to the consensus, that's a strong consensus.
A. That's a very strong consensus.
Q. Okay. You agree with me that the majority of PJIs, periprosthetic joint infections, are initiated through the introduction of microorganisms at the time of surgery.
A. Yes.
Q. Okay.
A. Is that one of the --
Oh, never mind.
Q. Why would you abstain, by the way, from --
A. I'm -- I'm only abstaining right now because I don't know the context of what was being discussed since all those questions, they were part of group discussions and meetings.
Q. Okay.
A. And as I said, that, you know, whether it comes directly on the skin or from the air, I don't

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totally believe that it's all airborne that leads to infections.
Q. Okay. Sitting here today, can you tell me what percentage of periprosthetic joint infections come from airborne bacteria as compared to from the skin?
A. I can't give you exact percentages.
Q. Okay.
A. And maybe it's saying the same thing. It may be that, airborne, but no, I view it more of the skin. That's why I spent my life disinfecting skin and -- or the -- or the wound itself or what you're doing in the case with your instruments and what you're touching. So I have a little hard time with that whole statement.
Q. Well --
A. I mean the surgeons, what they're doing in the case and their gloves get penetrated and the instruments may get contaminated and the skin is there, and as the case goes on they're sweating from the skin and --
Q. Would -- would --
A. -- and things like that. So to make that statement, that's why I might abstain or disagree. But maybe, depending on the context of that statement,

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I would --
Q. And you would --
A. -- I might agree with them the way it was presented.
Q. You would agree with me that after disruption in the unidirectional flow, the instruments and even the hands of the surgeon might be contaminated; correct?
A. Potentially.
Q. Okay. And you would also agree with me that if the implant is uncovered, that any disruption in the unidirectional airflow could cause the implant to become con -- contaminated; correct?
A. Correct.
Q. Okay. On page six --
MR. ASSAAD: Doctor, I have about one hour left, and I'd appreciate your attention --
THE WITNESS: I'm sorry.
MR. ASSAAD: -- to the deposition instead of --
THE WITNESS: Okay.
MR. ASSAAD: -- being on your phone.
Q. On page six of Exhibit 5, bottom of the first paragraph, it says, "...turbulent air systems are not sensitive to airflow disruption in the manner

purportedly demonstrated in these experiments involving laminar flow."

What's your basis behind that statement?

A. It's page six --

MR. C. GORDON: Of his report.

MR. ASSAAD: Of Exhibit 5.

MR. C. GORDON: Yeah.

THE WITNESS: Yeah. What line?

MR. C. GORDON: I'm sorry, I thought you said the deposition.

THE WITNESS: What line?

Q. The first par -- the par -- paragraph up at the top, the fourth line from the bottom of that paragraph starts with, "However, turbulent air systems are not sensitive to airflow disruption" --

A. I don't --

Page six.

Q. Page six.

A. I don't see it on the fourth line.

Q. Fourth line from the bottom of the first paragraph.

MR. C. GORDON: Can I point him to it?

MR. ASSAAD: Yeah.

A. Oh, fourth from the bottom --

Okay. It's not the fourth line, that's the



eighth line.

Q. Okay. I'll read it again.

Question: You state, --

A. Okay. So --

Q. -- "However, turbulent air systems are not sensitive to airflow disruption in the manner purportedly demonstrated in these experiments involving laminar flow."

What is your basis that turbulent air systems are not --

A. I -- I --

Q. -- sensitive to airflow disruption?

A. I was looking at a few articles, and laminar flow is -- is a completely different scenario than turbulent airflow that we would use at Cleveland Clinic, for example.

Q. I'm more specific to your -- your statement that they're not as sensitive to airflow disruption as laminar flow.

A. I saw some reference. I'd have to find that for you.

Q. Would it be in Exhibit A?

A. It would be in -- it would be in -- it would probably be in one of those.

Q. Okay. But --



I don't want you to look, but you, sitting today, you -- I mean you can't cite the name of the article sitting here right now this instant.

A. No.

Q. Okay. Do you agree with me that you need fewer CFUs to cause a periprosthetic joint infection than a superficial wound infection? Correct?

A. Correct.

Q. Okay. You just disagree with our experts that you only need one.

A. That could be a little bit of a semantic. Are we talking one growing to a million or --

Generally, inoculums, when you have small inoculums that are in the hundreds or thousands, they don't create infections. I did some of this work that wasn't published with fracture work myself personally. When you had small inoculums of bacteria, no infections occurred even though -- and there were -- and there were like thousands in fracture-healing scenarios, so I know that you could -- any one could turn into a million, but in a general --

When we're talking about creating an infection, you need -- in many of these, even the animal models that I cited, it was still like a thousand before that was inoculated, before infections



occurred in the animal models even with prostheses.

Q. Okay. But are you aware -- you --

Have you ever looked at an implant under an electron microscope?

A. I have looked at implants --

Q. Okay.

A. -- under electron microscope, on scanning electron microscopy with various techniques.

Q. And -- and you agree with me that even though the implant might feel smooth, in some areas there's always crevices because the metal is not perfectly smooth.

A. Well there's no artificial --

It's not perfectly smooth. I mean some people get worn -- things get worn as they're used.

Q. I'm talking about when they are brand-new, like when you put them in.

A. They're pretty smooth. They meet pretty good standards. They're pretty smooth, but of course there's crevices.

Q. Okay. And you agree with me that it's very difficult for the host to -- to fight off a periprosthetic joint infection.

MR. C. GORDON: Object to the form of the question.

A. In a general sense, yes.
Q. And that's why --
A. Yes.
Q. That's why the standard of care is to do a -- a two-stage revision usually.
A. Okay. You're -- you're -- now you're -- I was going to give you the general question. So let's go back. The host -- What type of infection?
Q. Like --
A. What, where, when, how, deep infections, superficial, this -- And we don't always use two stages, we use one stage sometimes. Now the field is turning into a lot of people where we use debridement, it depends on where the infection is, and now we're even turning into a lot of people saying we would like to do one stage rather than two stage. So let's go back and ask the questions a little bit more precisely.
Q. Okay. Well in the past, if there was -- if -- if it was found that the prosthetic joint was infected, had infectious material around it, the standard of care was to do a two-stage revision.
A. Are we talking about a hip or a knee? Are we talking --



Q. A hip.
A. -- an early infection, a late hematogenous one, are we talking about an acute one or subacute? So I published papers on infections in knees caught within 30 days and the standard of care that I developed, which a lot of people follow, is just wash out the plastic, wash out like a maniac, and I was able to save like 80 percent of those prostheses without a two-stage. That's published in the '90s.
Q. Okay. And sometimes you would have to do a two-stage.
A. Sometimes, yeah.
Q. Okay. What about with hip?
A. Hips, again it depends on how early. Sometimes when you catch these really early, within a month, you can bring it back, wash it out. Sometimes in those cases -- it depends on what it looks like in the OR -- we can do a one-stage right then, just take out the stem and the cup and clean it out and -- or -- There's different treatments. Each -- each one dictates. But in a general sense, just to cut to the chase here, when you get a deep infection that's caught a little late or it's postoperative and it's caught like two months later, it doesn't look that good, in a general sense the general standard of care



is just take it all out and put an antibiotic spacer and do it as a two-stage, which is I think where you may be leading.
Q. Assuming that, when the Bair Hugger is turned on in an operating room, that the particles increase over the surgical site, would that cause you any concern?
MR. C. GORDON: Object to the form of the question, increased -- incomplete hypothetical.
A. So -- so I don't know -- Again, it's the same question that I might have gotten trapped before and I don't know what you were asking me. Are you talking about like an extra one or two particles? What do you mean by "increased?" And we're talking now about particles. It might depend on a lot of different things like the amount of particles, what I just said, the size of the particles or something like that --
Q. Well --
A. -- whether -- whether -- whether those were -- It wouldn't be concerning me if they were non-pathogenic particles. How's that for an answer? But again, you'd have to ask the question differently.
Q. Let me ask you this: If you found out a



device increased the particles above the surgical site, okay, would you agree with me that you'd want to investigate that as an orthopedic surgeon, to whether or not that could be harmful to your patients?
A. Maybe or maybe not. I -- I already know that the -- having the lights above my surgical site create these particles, or dust, they're particles that we're -- we're a little concerned about but generally surgeons are not that concerned about. They think the -- You know, there's been UV radiation. The OR has generally low CFUs and those aren't -- they're not as worried about those types of particles. So I would be asking more questions.
Q. You'd ask questions; right?
A. Sometimes.
Q. Okay. And you agree with me that -- Well. You agree with me that people shed skin squames; correct?
A. Yes.
Q. And as a -- And the purpose of the ventilation system, unidirectional like the oper -- the circ -- the operating rooms that you use, is to push those skin -- skin squames down to the floor and out to the sides;

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correct?
A. That's -- that's been described, yes.
Q. Okay. So you -- and that's one -- one of the reasons why surgeons --
Well you -- you do agree that surgeons believe anything under the operating room is -- is not sterile -- operating room table is not sterile.
A. Correct.
Q. Okay. That's probably --
I would assume -- and this is an assumption, you could agree with me or not -- that probably the largest bioburden in the operating room table -- or in the operating room is probably on the sides and underneath the operating room table.
A. I -- I can't totally agree with that. I mean that's a large part. What about the garbage pail?
Q. I'm talking about --
A. I mean what about the people themselves? They're walking around, the people that are not even scrubbed and they're walking around. Look what their bodies look like.
Q. Would you agree there's a large bioburden underneath the operating table and around the operating room table?

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A. Yes.
MR. C. GORDON: Object to the form of the question.
Q. And if you found out that a device was bringing up that bioburden from underneath the operating room table and putting it over the surgical site, would that cause you any concern?
A. That would cause me concern.
Q. Okay. Because you would agree with me that particles -- there's a high probability of particles underneath the operating room table, some of them are going to contain pathogens.
A. No. They're --
We've just done an experiment where we were using a BioTrack device, which is evaluating bioactive particles, and we're finding that there's only like one in a thousand particles are -- are -- have bacteria in them. Low amount. And then it also has different size particles, and some particles I wouldn't be concerned about if they are -- because they wouldn't be harboring bacteria. I don't think they would be harb -- harboring virus; I'm not worried about viral infections. So if they're particles that are under .3 microns or something like that, I'm not that worried about that.

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Q. Do you know --
A. So it would depend on a few things like that.
Q. Do you know what percentage of skin squames contain pathogens?
MR. C. GORDON: Object to the form of the question.
A. Well when they're in the body -- well we don't know what --
No. I don't think anybody knows that.
Q. Okay. Well I'm not asking if anyone knows that. Do you know that?
A. What do --
How do you define "pathogens?" Do they have bacteria in them, --
Q. Yes.
A. -- is that what you're asking?
When they're in the body, probably a hundred percent have bacteria settle on them.
Q. What about skin squames that are shed from human beings during a surgical procedure, do you know what percentage of those skin squames --
A. I think I've seen different numbers for that, so I wouldn't put any number on that.
Q. Okay. Would you agree --

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A. Nor would I just --
Q. -- it's more than one percent?
A. I'll go for --
I don't know.
Q. Okay.
A. Because if it was more than one -- look at your numbers. If it was more than one percent, you just said nine million are hitting into a body or something, then -- then you're telling me that we're getting 90,000 bacteria that are hitting into a wound?
Q. I didn't say hitting into a wound, sir. I'm talking about shedding from humans. What percentage of those skin squames that are -- are shed from a human contain --
A. No. At some point you said that --
Q. -- contain CFU --
THE REPORTER: Just a moment.
THE WITNESS: I'm sorry. You're right.
THE REPORTER: "...are shed from a human" --
Q. -- contain CFUs?
If you don't know, that's fine.
A. Okay. We'll pass on that. I don't want to say a wrong answer.
Q. Okay. You -- you mentioned something about you're not concerned about viral infections; correct?

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A. I'm concerned about viruses any time, but not -- it's not typically what leads to infections here, periprosthetic infections.
Q. Okay. But bacteria causes infections; correct?
A. Well there -- there's also -- there's fungal infections also. They're very rare.
Q. Okay.
A. So that wouldn't be a bacteria.
Q. But the majority of periprosthetic joint infections are caused by bacteria; correct?
A. Yes, the greater majority.
Q. Okay. You -- you agree with me that the fact that someone's obese, without a bacteria that -- that enters the surgical site you're not going to have an infection.
MR. C. GORDON: Object to the form of the question.
A. The fact that somebody's obese --
Q. Obesity doesn't cause infections; correct?
A. Well that was that earlier question that I got asked and some of it is maybe the way I phrased it. Obviously, a bacteria causes infection in the way that other sentence was phrased, that obesity would be a risk factor, and it would depend on the amount of

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obesity --
Q. It makes you more susceptible.
A. It would make you more susceptible.
Q. Just like diabetes, you might be more susceptible.
A. Right. That's what was meant from the phrase, --
Q. Okay.
A. -- not -- not that --
Q. Okay.
A. -- these risk factors cause the infection, which -- which might have been implied by that --
Q. And that --
A. -- ill-worded sentence in the beginning that I got asked about.
Q. And that's what I was trying to correct, is you're not saying that the fact that somebody is a diabetic or obese or any other type of risk factor is -- is -- is the cause of the infection. You still need the bacteria to cause an infection.
A. Yeah. If you -- the only qualify, if you operated --
Bacteria is the cause of an infection. There are sometimes we operate -- we have operated on people that might have had an unknown bac -- dental

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infection and -- or they had an ulcer that wasn't detected, you find out later, so -- so it's an actual -- a nidus of bacteria that led to the infection. You might find that out later in certain cases. Actually --
And certainly, yes, periodontal disease and an ulcer disease on somebody's leg --
Q. You still need bacteria though.
A. -- is a risk factor, but it comes from bacteria, just may not --
(Witness's cellphone dings.)
A. But that's a risk factor. Nobody paid attention to it.
Q. It may have not come from the skin or the air, but you still need a bacteria.
A. Yes.
Q. Okay.
THE WITNESS: I'm just going to answer one thing, but I can hear a question.
Q. Have you ever been involved in the design of a patient warming device?
A. No.
Q. Now you agree with me -- well strike that.
I know you disagree that the Bair Hugger has an effect on contaminating the sterile field, but if

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it did have an effect on contaminating the sterile field, you agree then it would be a defective product; correct?
MR. C. GORDON: Object to the form of the question, calls for a legal conclusion.
THE WITNESS: Does that mean I answer it?
MR. ASSAAD: Yes.
MR. C. GORDON: It's whatever you can answer.
A. If a device -- am I allowed to answer -- causes bacteria into a sterile field, would I agree that we shouldn't be using that device? Is that your question?
Q. Yes.
A. Yes.
Q. Okay. Now I noticed that you comment in your report -- on pages 13 and 14, 15 and 16 -- on the McGovern article; correct?
A. Yes.
Q. All right. You mentioned that the McGovern article could be explained by the Hawthorne effect. Do you remember saying that in your report?
A. Yes.
Q. Sitting here today, have you talked to any of the -- any of the physicians or researchers that

did the -- that published the McGovern article and ask whether or not they considered whether or not the -- the results could have been affected by the Hawthorne effect?

A. No. First of all, I haven't talked to any of these physicians in the whole thing, so why are you --

Q. Have you read the depositions?

A. I saw those depositions.

Q. That wasn't my question. Have you read those depositions?

A. Oh, the --

Oh. The answer is yes, I read them.

Q. Okay. So you read Dr. McGovern's deposition?

A. Yes.

Q. You read Dr. Reed's deposition?

A. Reed.

Q. Do you know Dr. Reed right now is -- is --

A. And Leaper.

Q. -- is working on a -- a study funded by 3M?

A. Dr. Reed.

Q. Yes.

A. Yeah.

Q. You know Dr. Reed personally?



A. No. He sounded like he was very interested in some knowledge and interested in this topic, in reading the deposition.

Q. Are you aware --

A. I'm aware of that.

Q. Are you aware that 3M right now is conducting a pilot study with respect to forced-air warming and infection rates on certain types of -- of orthopedic surgeries?

A. Yes, it was mentioned --

Well I don't know exactly where it is. It was mentioned in the deposition.

Q. Okay. So sitting here today, your -- would you agree with me that your opinion that the results in McGovern could be explained by the Hawthorne effect is just speculation on your part?

A. This --

You're asking me about the Hawthorne. This is one of the worst -- based on looking at this thing, this is one of the worst results articles which could be explained by not only the Hawthorne effect, by multiple, multiple other effects which I elaborated in this report, and many of those effects that are in this report were even further published in one of the citations here from U.K. of all the changes that were



done that weren't mentioned in the McGovern article, all of which had effect in this period of time. So not only --

You said did I speak to these people. No, I didn't speak to these people, but this is like everything that I put in there, and there's a lot more, and it's even been published about all these things that were done at the time of this study, and they -- and in addition to that publication from U.K., the same authors published other things about some of the factors that I mentioned like the antibiotic change and the anticoagulant change, et cetera, so you know what, your ques --

I never spoke to these people, but it's almost like they spoke to me multiple times in the literature -- it's amazing, they really did -- to tell me all the confounding factors and the reasons why you couldn't take any credence to the results of that study.

Q. Prior to submitting your report by June 2nd, you reviewed under Exhibit A the -- the expert report of -- of Dr. Holford. Do you recall citing that to Exhibit 8?

A. Exhibit 8 or A?

Q. A of your report, Exhibit 8 of this



deposition. Defense expert report.

A. Oh, yeah, yeah. Holford.

Q. Have you relied on his opinions in formulating your opinions?

A. Not really.

Q. Okay. Now also on Exhibit 8 --

A. You mean A?

Q. Yeah, but it's eight of this deposition. It's been marked as Exhibit 8.

A. Oh, I apologize.

Q. Okay.

A. Sorry.

Q. I know that's probably confusing, but exhibit -- I'm going to use the exhibit depo -- the number for this deposition.

A. Got it. I got it.

Q. You mentioned that you had Mark Albrecht's deposition; correct?

A. Yes.

Q. But I don't see where you spend time reading it --

Oh, never mind. I do. You read that in May of 2017?

A. Whenever it was marked as --

I tried to be as accurate as I could with

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when I read things --
Q. Okay.
A. -- in the -- in the invoice.
Q. Did you have a copy of Dr. Nachtsheim's deposition?
A. Nachtscheim. Doesn't ring a bell.
Q. Did you receive any internal documents from 3M?
A. Internal documents from 3M. I don't know how --
You'd have to define that for me. The only thing from 3M that I remember reading at the very beginning, I went to the websites and I went to -- there were like a lot of things about 3M on the website, there were like 14 different panels and YouTube videos. I wanted to become familiar.
When it comes to 3M, what did -- what else could I potentially have gotten?
Can you ask the question again?
Q. Let's may -- maybe --
A. I mean I'm unsure --
Q. -- do it this way. Is Exhibit 8 everything that you considered prior to submitting your report?
A. Exhibit -- okay. Exhibit 8, everything that exhibit -- I will --

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To the best of my knowledge, the answer is yes. But I'm happy, because I don't want to be inaccurate, to --
Q. All right.
A. -- to -- to think in my brain is there something I didn't --
It's -- it's certainly possible there's an article or two that I might have just had a lapse and didn't put it in because I just thought it was common knowledge, --
Q. Okay.
A. -- something I had published that I didn't think I needed to put in the report, something like that.
Q. Did you pull all these articles your -- yourself, or did people from 3M or their attorneys provide some articles to you?
MR. C. GORDON: Object to the form of the question.
A. Most of these articles I pulled myself or looked at before the report. Most of -- most of the articles, if -- I looked at the article or the abstract or something online or looked at some internet things. Sometimes it was internet, sometimes it might have been -- in answer to your other question

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before -- it might have been from a 3M website, it might have been from some other things. So that was before the report. There might have been a few exceptions and I'd have to look at this and tell you the few exceptions where --
Q. Well let me ask it --
A. But most of these reports I pulled myself or -- or saw an abstract. I didn't have every full report before the June 1st or 2nd thing. I had some that I relied on abstracts.
Q. And you agree with me that some of the articles were provided by 3M or -- or their attorneys.
A. I am not sure.
Q. Okay.
A. I'd have to go through one by one. It could be that none or both, meaning I had the abstract and then they -- I said, "Do you have this paper?" Or I saw reference to something and then they got me this.
Q. Now you mentioned that --
In the McGovern study you mentioned something about the prophylactic antibiotics and the anti -- or the prophylactic antithrombosis drugs; correct?
A. Yes.
Q. Okay. Do you agree with me that it is

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possible that those -- like, for example, the prophylactic antibiotic -- may have had no effect on infection rates? Correct?
A. Well in this particular study, when there was pound per pound the same antibiotics used, there was -- there was no difference in infection rates. It's right there, first six- or seven-month period.
Q. So you're saying when the -- when -- when -- when the antibiotic switched, there was no difference in infection rates?
A. In data that was provided to me, when they -- when concurrent antibiotics were used, there was no difference -- in the six- or seven-month period there was no difference in infection rates. When you're mixing and matching antibiotics and in one group you have differences, then --
Q. You're not opining that the -- that the change in the antibiotics had an effect on the infection rates; are you?
A. It certainly could have had an effect. Yes, I am opining that.
Q. Certainly could or -- or are you --
Are you saying it's a possibility or a probability?
A. Probability.

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Q. Okay. And your basis?
A. That when you look pound per pound at patients treated with the same antibiotics, they have not a 3.8- or four-fold difference in infection rates, they're the same.
Q. Okay.
A. So that's -- so that's why it's more likely than not, which is what I said.
Q. You looked at the raw data?
A. Yes, I saw raw data --
Q. And --
A. -- for a six- or seven-month period.
Q. Okay. And have you read the deposition of Albrecht or Reed or McGovern?
A. I read their depositions. In addition, they have the same effect for their antico -- they published a difference of infection rates, five to 13, and they called that non -- when they were using anticoagulants, and they didn't account for that as well, and they called that a non-significant increase. Well of course it's non-significant, it's 13 versus five. Thirteen versus five is a tremendous increase when you're using different anticoagulations, so they even published a paper on that whole effect in terms of infection rates when they were using the

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anticoagulant with the Bair Hugger device. So they had a lot of confounding factors.
In addition, they even admitted in the deposition that they had cases that they put maybe in the wrong category, and that was admitted by McGovern.
Q. And you also read in the deposition that the data that was provided to them by -- by defense counsel, they weren't sure if that was the final data used for the study; correct?
A. Yeah, that --
I mean there was at lot of e-mails like that.
Q. Okay.
A. So -- so if you want to provide me different information to look at --
But I certainly looked at a lot of things like that.
Q. Okay. Have you read Dr. Holford's deposition?
A. To some extent.
Q. When did you receive his deposition?
A. Hmm?
MR. C. GORDON: Deposition or expert report?
MR. ASSAAD: Deposition.
A. I don't know if I read his deposition.

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Q. By the way, on Exhibit 8 you put down "Plaintiffs' Studies" on page two, and then "Other articles and materials (in addition to those specifically cited in my report)."
What makes you believe that those studies under --
Why did you title it "Plaintiffs' Studies?"
A. All right. You're asking me too many questions at once. Start with this one now?
Q. On page two --
A. Page two of what?
Q. -- of Exhibit 8 --
A. Of eight.
Q. -- you have a title that says "Plaintiffs' Studies."
A. Oh, because -- all right. Maybe --
Because some of these -- I view some of these, as the ones of Albrecht, that he is somebody that worked with the company at the time.
Q. Is there any evidence --
A. Maybe I'm -- maybe I'm mistaken, and if I am, then I can cross that off.
Q. Are you aware of any -- any studies sponsored or funded by any of the plaintiffs or their attorneys in this case?

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A. Yes. There was mention by McGovern and I think by Reed that there were some studies that were being sponsored or -- or --
Yes.
Q. By the plaintiffs?
A. By Augustine and that group.
Q. Do you believe Augustine is a plaintiff in this case?
A. All right. Now we're mix --
Okay. I don't want to get into this discussion right now.
Q. I'm asking you: Do you think Augustine is a plaintiff in this case?
A. No, he's not a plaintiff.
Q. So --
A. I'm talking about that side of the case, the people that have a --
All right. Let's --
Q. I mean --
A. All right.
Q. -- you put in "Plaintiffs' Studies." I'm just trying to determine why on Exhibit 8 you put in "Plaintiffs' Studies." What were -- what were you informed to declare that the eight studies listed there are plaintiffs' studies?

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A. I will put Augustine as a person that has a vested interest in his conduction-fabric de -- his Hot Dog device that has put out tremen -- when I got introduced to these studies, tremendous information as if he was a plaintiff against these devices, so that's why I put that in the category.
Q. So --
A. These -- these are -- these are studies that are done by people from that device company. So if you want, I'll be happy to cross that out.
Q. Does -- does it take away any credibility of those studies?
A. Yes.
Q. So you're saying that a study that's funded by a corporation that has a vested interest in what those studies are saying are not credible studies?
A. No. But they -- they -- they have to be disclosed. And perhaps some of those studies were not published. As we heard from McGovern's testimony, it was pretty interesting how he was a young fellow that wanted to publish papers and multiple times wanted to publish the work that showed non --
Q. You mentioned earlier --
A. So --
Q. -- you had an unpublished study; correct?

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A. Hmm?
Q. You mentioned earlier that you had some unpublished studies.
A. What does that have to do with what I'm saying right now?
Q. I mean the fact that something is unpublished, does that make a difference if it's unpublished or not?
THE REPORTER: Just a moment.
MR. ASSAAD: Sorry.
THE REPORTER: What's the question?
Q. If -- if a published --
If somebody does a study and unpublishes it, is that -- do you hold that against them?
A. You're taking it out of context. This is a person that wanted to publish this multiple times. You can read his deposition, and these were the queries that were made. But we can keep talking about this if you'd like.
Q. I mean before --
You've done tests before to see what's the best way to perform a study, little pilot studies; correct?
A. Yes.
Q. Okay. And some may work and some might not

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work; correct?
A. Correct.
Q. Okay. For example, if I did a particle-counting test above the surgical site and it showed an increase in particles, you'd come back and say that's not a good study because particles don't equal bacteria; correct?
MR. C. GORDON: Object to the form of the question, incomplete hypothetical.
A. Say it again.
Q. If I had a study that -- that showed the effect of the quantity of particles created by a medical device over the surgical site, you might not -- you might criticize that study or say it's not a valid study because particles don't equal bacteria; --
MR. C. GORDON: Object to --
Q. -- correct?
MR. C. GORDON: Object to the form of the question.
A. It might or might not. It would depend on the size of the particles, the amount of particles, --
Q. Okay.
A. -- how the study was done. There's a lot of different effects of it.

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Q. There are many reasons why people don't publish studies; correct?
A. Correct.
Q. And sitting here today, you're -- you're not aware of many unpublished tests that 3M performed internally or Arizant performed internally regarding the Bair Hugger and its effect on airflow.
A. I can --
No.
Q. Okay. In the consensus, do you agree with the consensus that further research is required with respect to the significance of patient normothernia -- normothermia on orthopedic surgeries?
A. Yes.
Q. Do you agree with the consensus that further study is needed with respect to the theoretical risk posed by forced-air warming blankets?
A. I don't mind the statement.
Q. So you -- you would agree.
A. I would agree.
Q. I'll read the whole thing for you, so --
A. Well there was a study. The -- the Siguera study was on forced-air warming.
Q. The what study?
A. You just --

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We just discussed it during this whole deposition.
Q. I didn't hear what you said. Which study?
A. We discussed the Siguera study.
Q. Siguera?
A. Higuera. The Cleveland Clinic study --
Q. Oh, Higuera. Okay.
A. -- was a study done on forced-air warming.
Q. Well let me read the question. "Do forced-air warming blankets increase the risk of SSI?"
Consensus: "We recognize the theoretical risk posed by forced-air warming blankets and that no studies have shown an increase in SSI related to use of these devices. We recommend further study but no change to current practice."
Do you agree with that?
A. Yes.
Q. Okay. If there was going to be further study with respect to whether or not forced-air warming increases the risks of surgical-site infection, who do you think would be responsible for funding that study?
MR. C. GORDON: Object to the form of the question.
A. You just saw a study that -- that was funded

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by 3M but it was from a ret -- from a prospectively-gathered database of -- from Cleveland Clinic.
Q. But that's --
A. So it might be 3M, it might not be 3M.
Q. Well would you agree with me that the most likely person that would be funding a study such as that would be the manufacturer of the device?
MR. C. GORDON: Object to the form of question, lack of foundation.
A. Sometimes, sometimes not. But yes, I'm okay with what you said.
Q. And the study funded by 3M between forced-air -- before -- between the Bair Hugger and the Mistral doesn't really answer this question; does it?
MR. C. GORDON: Object to the form of the question.
A. Well it almost does, because there's no increased rate with infections.
Q. Well this is asking, "Do forced-air warming blankets increase the risk of SSI?" Wouldn't you agree with me that both the Bair Hugger and the Mistral are forced-air warming blankets?
A. Yeah, but look at how low they are, these infection rates at Cleveland Clinic.
Q. Yeah. But it could -- it could be because

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forced-air warming in general increases the risks of SSI. You can't say --
You can't compare two forced-air warming blankets and say, "Oh, since they're close, there's no risk of forced-air warming blankets increasing the risk of SSI;" can you?
MR. C. GORDON: Object to the form of the question.
A. May be a good thing for me to look at, see when they --
But I don't know if we can.
Q. I mean, doctor, you can't compare two products with the same form of warming, both forced-air warming, and say they're no different, "Oh, and by the way, they don't increase SSIs" when you have --
A. Well if the rate of infections are so minuscule, you could say it's very unlikely that they increase SSI. They are so minuscule compared to the national average and national standards that it would be, again, unconscionable to do the study because here's a study of not what you said to me before with your 40 versus 40 -- 80 patients, here you've got 5,000 patients and you have such a low rate of infection that maybe that should -- I didn't even

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think of it. Maybe I should remind them that they should mention that it's unlikely that FAW increases infection rates when you have two patient populations with FAW that have such low infection rates. That might be the proof right there --
Q. What's your control?
A. -- I didn't think about.
Q. What's your control?
A. I don't need a control.
Q. You don't need a control in a study?
A. You do need a control in general, but when the rate is so low, you wouldn't even --
Why would you do a control? You don't want to take a chance. It would be -- it would be -- it would be un -- immoral and unethical to do it.
Q. But you're looking only at the first 90 days, correct, in the study?
A. You can keep saying that all you want, but 90 days is --
Q. I'm --
It's a study that you're citing to, doctor.
A. That's what the CDC wants us to look at is 90 days right now.
Q. But you're aware that periprosthetic joint infections can occur up to a year.

A. But they are wanting us to look at 90 days --
Q. I don't care.
A. -- right now.
Q. Doctor, you just admitted earlier that these type of infections occur -- occur during the surgery; correct?
A. So this is -- so --
Q. "Yes" or "no?"
A. Fair enough.
Q. Okay.
A. We -- we can look at this up to one year as a future study, and then I might be able to make the conclusion that I did.
Q. Maybe even up to two years. Sometimes they show up two years later.
A. Sometimes they show up five years later.
Q. Up to five years; correct?
A. Ten years, 15 years. I've seen people 14 years later. I don't know what you're driving at.
Q. I'm saying a periprosthetic joint infection can occur up to 15 years later after a surgery occurred.
A. Well we --
It depends. Are we going to talk late



hematogenous infections or postoperative infections? They have different definitions. Clearly, anything could happen that -- that gets harbored.
Q. But you would agree with me that there's a significant number of periprosthetic joint infections that arise after the first 90 days --
MR. C. GORDON: Object to the form of the question.
Q. -- after surgery.
A. Most of the infections arise in the first 90 days, so I don't know what your term called "significant" is.
When we did the study, the greater majority were in the first 90 days.
Q. Have you --
Are you familiar with the article by Parvizi with respect to the economic burden of periprosthetic joint infections that track PJIs over something like 2001 to 2012?
A. He has a lot of articles, --
Q. Okay.
A. -- so I don't know which one you're referring to. He's published, you know, 50 articles a year on -- or some number like that on periprosthetic infections, so you'd have to show me which article.



And you can ask me the point you're trying to make.
Time check: It's 10 to 5:00.
Q. What is the national average for primary periprosthetic joint infections?
A. Depends on which database. I mean some --
I don't know what the latest is. And the hip and knee might be a little different. But my -- and also the data is a little old.
I would say it's about 1.5 percent, would be my best guess. But again, you would have to depend on What population are you looking at? There would be regional -- regional differences. What year are you talking about? The latest data I think is from 2014, so --
Yeah. In fact I'm pretty sure that's the case.
Q. Roughly 1.5 percent, that's --
A. Maybe something like that. Maybe two percent.
Q. What about revisions?
A. Revisions, much higher.
Q. What percentage?
A. That's too variable for me to give you a number. I've published on this, but depends on the database you're looking at.



Q. More than two percent?
A. Yes.
Q. What percentage of those revisions are due to infections?
A. What --
Most studies show that about 20 percent of revisions of knee or hip are due to infections. But that's variable also.
Q. Are you familiar with the SCIP protocol?
A. Yes, I am.
Q. Is even using -- for you, who does these surgeries anywhere in between 22 to 45 minutes -- is using a Bair Hugger device indicated for that time and length of surgery?
MR. C. GORDON: Object to the form of the question.
A. Why wouldn't it be?
Q. Well have you read -- have you read the SCIP protocol regarding when you should use a -- a -- a warming device on a patient?
A. I didn't -- from my end --
First of all, when I said to -- "skin to skin," that has nothing do when a patient's put on a table and this and then draped and taken off the table as well.

Q. Okay. By the way, do you use the Mistral device at Cleveland Clinic?
A. Presently that's what's being used.
Q. Have you read the warnings for the Mistral device?
A. No, I have not.
Q. Would you be surprised if the warnings indicate that use of this device may cause airborne contamination?
A. I -- I don't know. I'd have to read that. I don't want to say anything out of context. Obviously --
Q. I asked would you be surprised.
A. Maybe. Yeah, maybe --
Q. And you're aware that --
A. -- if you don't use the device right, you don't check -- you don't change the filters right, you don't do certain things correctly, don't apply it right.
Q. Have you looked at the warnings for the Bair Hugger device?
A. No, I haven't.
Q. Okay. And just so I understand, based on the -- based on the consensus, orthopedic surgeons care about particles over the surgical site; correct?



MR. C. GORDON: Object, object to the form of the question.
A. In a general sense, yes.
Q. And you would expect a corporation or a company that manufactures a medical device to indicate whether or not there would be an increase in particles over the surgical site if they're aware of scientific data that shows that -- that -- that shows that fact.
MR. C. GORDON: Object to the form of the question.
A. Not necessarily.
Q. I mean wouldn't you want to know the safety of your patients?
MR. C. GORDON: Same objections.
A. You said that in -- in a whole sphere, one or two particles increase, when everything else is increasing particles by thous -- hundreds and thousands, then no, you're -- you're -- you're putting something way out of context.
Q. So you're saying depending on the amount of particles would decide whether or not orthopedic surgeons should be warned?
A. That would be part --
That we're talking generically for any device, it would depend on the amount of particles.



And are we talking about a particle that's from some object from -- from one that crosses the room seven feet across and hits into the wound, one particle, versus the hundreds that are being shed by the lights and all these other sources? The answer is no, you wouldn't make a warning on that.
Q. What about --
A. So everything has to do with degree.
Q. What about a device that's placed right next or underneath the operating room table. As an orthopedic surgeon, would you want to know if that had an effect on the particle count over the surgical site?
MR. C. GORDON: Object to the form of the question.
A. I guess in a general sense I'd want to know about --
I'd want to know a lot of different things in my operating room.
Q. Would you want to know that fact? If you had a medical device that was sitting underneath or next to the operating room table that showed an increase in --
A. Well --
Q. -- particle counts over the surgical site,



would you want to know that information?
A. But we have a de --
MR. C. GORDON: Object to the form of the question.
A. We have a device in multiple, multiple, multiple studies, as I enumerate in my report, which I looked at carefully, that showed no increase in bacteria to a surgical site multiple times by the company, that showed negative effects, many studies that didn't show increase in particle counts, et cetera. So the answer is: These studies were done and they were done over many years, they were done, as you would say, with many different device types of the same general forced air, and they were -- they were published, not only were they done, they were published, and they showed no study showing increased bioburden at operative sites. So the answer is yes, you'd want to know that, but in fact there was good diligence done, multiple, multiple studies, they're enumerated there, that do not show increases in bacterial bioburden at the operative site. So what more can you do?
Q. And the studies that show the opposite that were funded by Augustine -- or -- or not funded, but Augustine donated some of the equipment, you don't

hold that -- you don't hold those studies as being credible studies; correct?
MR. C. GORDON: Object to the form of the question.
A. Some of them I might, but -- but I don't -- but -- but he didn't show that.
Q. Are you aware that some of the studies that you use to support your opinions in this case were funded -- also funded by Augustine?
A. Yeah. So that's why I just said what I said in the previous thing, --
Q. So the --
A. -- that that's not necessarily true.
Q. So the fact that a study is funded by Augustine has no difference on the credibility of the study. You actually look at the study itself.
MR. C. GORDON: Object to the form of the question.
A. Of course I do. But when I hear depositions and things being said about some of the studies, I start questioning it.
Q. Okay.
A. Especially like the recent study that just got published. We --
Q. Okay. Well I don't want to talk about that



study.
MR. ASSAAD: That's all I have.
MR. C. GORDON: Thank you. We'll read and sign.
THE REPORTER: Off the record, please.
(Deposition concluded.)



C E R T I F I C A T E

I, Richard G. Stirewalt, hereby certify that I am qualified as a verbatim shorthand reporter, that I took in stenographic shorthand the deposition of MICHAEL A. MONT at the time and place aforesaid, and that the foregoing transcript is a true and correct, full and complete transcription of said shorthand notes, to the best of my ability.

Dated at Deerwood, Minnesota, this 3rd day of August, 2017.

RICHARD G. STIREWALT
Registered Professional Reporter
Notary Public



C E R T I F I C A T E

I, MICHAEL A. MONT, hereby certify that I have carefully read the foregoing transcript, and that the same is a true and complete, full and correct transcription of my deposition, except:

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MICHAEL A. MONT
Deponent

Signed and sworn to before me this ____ day of September, 2017.

_____
Notary Public